

12176

## 12219

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix, Maryland</b>		d. STREET ADDRESS <b>Stockton Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Alban</b>		4. DATE OF DEATH Month <b>11</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-28-1907</b>
9. AGE (In years lost birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Alban</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Parks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-22-4937</b>	
17. INFORMANT <b>Eleonora Alban</b>		Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Spinal Cord</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) <b>1933</b> (c) <b>1933</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 1948</b> , 19____, to <b>Nov. 1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>31 October</b> , 19 <b>60</b> , and that death occurred at <b>4 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cockeysville, Maryland</b> DATE SIGNED <b>2 November 1960</b>			
ACTUAL SIGNATURE <b>Walter T. Kees</b>		M.D. <b>Walter T. Kees, M.D.</b>	
PHYSICIAN'S NAME (Type) <b>Walter T. Kees, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-4-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Timonium Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service</b>		ADDRESS <b>Towson 4, Maryland</b>	
24a. REC'D BY REGISTRAR <b>11/3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)  
15M 9/58

# CERTIFICATE OF DEATH

12312

Baltimore

Maryland

Maryland

Maryland

Phoenix

John

Phoenix

Stockton Road

Stockton Road

11 1 1960

John

Henry

John

White

7-22-1907

Self-employed

Plumber

Maryland

Maryland

Above

Phoenix

217-22-4057

at

Delaney Valley Memorial

Phoenix

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12220

CERTIFICATE OF DEATH

12177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - White Hall</u>		c. LENGTH OF STAY IN lb <u>63 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett Road</u>		d. STREET ADDRESS <u>Garrett Road 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Wilmer</u> Middle <u>Grandison</u> Last <u>Almony</u>		4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1891</u>
9. AGE (In years last birthday) <u>69 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jarrett Garner Almony</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Anna Mary Trout</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Lida Almony (sister) - same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident (hemorrhage)</u> DUE TO <u>4443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>years</u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o). <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO INJURY</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19 <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <u>  </u> of work <u>  </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>60</u> , to <u>November</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>November 19</u> , 19 <u>60</u> , and that death occurred at <u>7:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James F. White, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Hawks Mill Rd.</u> DATE SIGNED <u>11/20/60</u>	
PHYSICIAN'S NAME (Type) <u>James F. White, Jr.</u>		<u>Jarrettsville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-23-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>W. LIBERTY METH. CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WHITE HALL, BALTIMORE CO., MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Orshum</u> ADDRESS <u>Stewartstown, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 22 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12221

## CERTIFICATE OF DEATH

12178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>3001 Edgewood Ave</b> <b>3V 01-4</b>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Alfred</b> Last <b>Appleton</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>White Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1895</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul Appleton</b>		14. MOTHER'S MAIDEN NAME <b>Anna Paul</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>1917-1919</b>		16. SOCIAL SECURITY NO. <b>Hospital Records.</b>	
17. INFORMANT <b>Hospital Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia.</b> <b>519.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pleurisy</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Nov. 1. 1960</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 28</b> , 19 <b>58</b> , to <b>Nov. 20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Nov. 20</b> , 19 <b>60</b> , and that death occurred at <b>8.25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>H. I. Cholmondeley M.D. SPRING GROVE STATE HOSP. 11/20/60</b>			
ACTUAL SIGNATURE <b>H. I. Cholmondeley</b>		PHYSICIAN'S NAME (Type) <b>H. I. Cholmondeley</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/29/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd.</b>		24a. REC'D BY REGISTRAR <b>NOV 29 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12218

12175

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
c. LENGTH OF STAY IN 1b <i>10 years</i>				d. STREET ADDRESS <i>1226 Bridgewood Drive</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>512 Rosewood ST. Tr. School</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Christina</i> Middle <i>Anna</i> Last <i>Airey</i>				4. DATE OF DEATH Month <i>Nov.</i> Day <i>20</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-12-50</i>		9. AGE (In years last birthday) <i>10</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Eugene Howard Airey</i>				14. MOTHER'S MAIDEN NAME <i>Augusta Anna Damico</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT Address <i>EUGENE H AIREY 7226 BRIDGEWOOD DR</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia (Bronch)</i> DUE TO <i>527-2</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic infiltration in both lung fields</i> DUE TO <i>lung fields</i> (c) <i>-</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Severe spastic quadriplegic Mental retardation</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>5/25</i> 19 <i>56</i> to <i>11/20</i> 1960 that (I) (we) last saw the deceased alive on <i>11-20</i> 1960 and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Harry G. Butler</i> M.D.				22b. DATE SIGNED <i>11/21/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>Harry G. Butler, M.D.</i>				22d. ADDRESS <i>Rosewood Lane, Crownsville, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>NOV 23 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GARDENS OF FAITH CEM.</i>		23d. LOCATION (City, town, or county) (State) <i>TRUMPS MILL RD MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Duffel Bros</i> ADDRESS <i>1800 E. Lombard St</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 23 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Travis</i>	

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1917

CERTIFICATE OF DEATH

1917



*[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]*

VR A1S (4)  
15M 9/59

## 12222

12179

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>3902 Southern Avenue</b>	
3. NAME OF DECEASED (Served as First <b>RICHARD</b> -Middle-- <b>ASHBURN</b> ) (Type or print) <b>RICHARD C. ASHBURN</b>		4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1877</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital Buildings</b>	
11. BIRTHPLACE (State or foreign country) <b>Independence, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Richard C. Ashburn</b>		14. MOTHER'S MAIDEN NAME <b>Alice Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>SAW</b>	
17. INFORMANT <b>Clinical Records</b>		Address <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIVISION</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM, RIGHT LUNG</b> <b>465X</b> <del>MYO</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRONCHOPNEUMONIA</b> <del>MYO</del> (c) <b>EDEMA OF THE LUNGS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>less than 1 hour</b> <b>4 Days</b> <b>6 Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old brain infarctf.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 18</b> <b>1960</b> to <b>Nov. 22</b> <b>1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 22</b> <b>1960</b> , and that death occurred at <b>12:05</b> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <b>John D. Talbert, M.D.</b>		22b. DATE SIGNED <b>11/23/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-25-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 28 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			



5551

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12180

12223

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balti.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>4 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				d. STREET ADDRESS <b>19723 HARFORD RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLARA MAY ATZROOT</b>				4. DATE OF DEATH Month Day Year <b>NOV 3 1960</b>			
5. SEX <b>FE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-24-1878</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>GEORGE A. DAVIS</b>				14. MOTHER'S MAIDEN NAME <b>EMMA GALLOWAY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-07-49250</b>		17. INFORMANT Name <b>Frank L. Smith Jr.</b> Address <b>Cockeysville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral &amp; generalized Arterio Sclerosis</b> DUE TO (c) <b>4 months</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-30 1960</b> to <b>10-2 1960</b> , that (I) (we) lost saw the deceased alive on <b>10-2 1960</b> , and that death occurred on <b>11-3-60</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter T. Kees</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>				22d. ADDRESS <b>COCKEYSVILLE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-5-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>NOV 7 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

12150

CERTIFICATE OF DEATH

12150

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12224**  
**CERTIFICATE OF DEATH**

**12181**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines Nursing Home</b>				d. STREET ADDRESS <b>1 N.Symington Ave. (28)</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Albert Austin</b>				4. DATE OF DEATH Month Day Year <b>November 28, 19 60.</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 16, 1874</b>		9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Feed Business</b>		11. BIRTHPLACE (State or foreign country) <b>W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas G. Austin</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Demarest</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-03-2369</b>		17. INFORMANT Address <b>Mrs. Rose L. Austin 1 N.Symington Ave.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Prostate with Metastases</b> DUE TO <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized atherosclerosis of secondary</b> DUE TO (c) <b>of secondary</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>11/29/60</b>	
21. I certify that I attended the deceased from <b>Jan 1960 to Nov. 28, 1960</b> , that I last saw the deceased alive on <b>Nov 28, 1960</b> , and that death occurred at <b>5:00 p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>M. Paul Byerly</b> <b>3033W Lark &amp; Balt 8/16 md</b>							
ACTUAL SIGNATURE <b>M. Paul Byerly</b> M.D.				PHYSICIAN'S NAME (Type) <b>M. Paul Byerly</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-1-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>G. Howard Strong 3207 W. North Ave.,</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

TO H-2, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13184

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

13334

Name of Deceased		Date of Death	
John Doe		Jan 15, 1950	
Age		Sex	
65		Male	
Race		Marital Status	
White		Married	
Place of Birth		Usual Residence	
New York City		123 Main St, Baltimore	
Cause of Death		Immediate Cause	
Heart Disease		Myocardial Infarction	
Duration of Illness		Period of Incubation	
2 weeks		None	
Place of Death		Attending Physician	
Home		Dr. J. Smith	
Burial Place		Funeral Home	
Catholic Cemetery		None	
Signature of Registrar		Signature of Physician	
[Signature]		[Signature]	
Date of Registration		Date of Death	
Jan 16, 1950		Jan 15, 1950	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12225

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12182

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 N. Beechwood Avenue</b>		d. STREET ADDRESS <b>8 N. Beechwood Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle Last <b>BACON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 6, 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>----</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hazleton, Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Christopher C. Heller</b>		14. MOTHER'S MAIDEN NAME <b>Enna G. Dodson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. John F. Bacon-Belfast Road, Spark, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>massive cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio Vascular disease</b> DUE TO (c) <b>1540</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>mild diabetes mellitus. Cord coronary occlusion</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1945</b> 19 <b>1945</b> to <b>December 1960</b> that (I) (we) last saw the deceased alive on <b>August 23 1960</b> , and that death occurred on <b>11/3/60</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C. Wilbur Stewart</b>		22b. DATE SIGNED <b>11/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. WILBUR STEWART</b>		22d. ADDRESS <b>6 E. Road SE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/4/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Monkton Methodist Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Monkton, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichner</b> ADDRESS <b>Baltimore - 17, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 7 1960</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Wm. J. Tichner</b>			

No. 1318

Date

No. 1333

Bibliography

Bibliography

Bibliography

Bibliography

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12226

12183

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>10 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Melanie Imboden Baxley</b>				4. DATE OF DEATH Month Day Year <b>November 23, 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 12, 1882</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Switzerland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Imboden</b>				14. MOTHER'S MAIDEN NAME <b>Mary Josepjene Iarien</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Md.</b> <b>Miss Catherine Baxley 18 Fusting Ave. Catonsville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic C.V.D.</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State) <b>11-23-60</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>11-22-60</b> to <b>11-23-60</b> , that (I) (we) last saw the deceased alive on <b>11-22-60</b> , and that death occurred at <b>3 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>James G. Howell</b> M.D.				22b. DATE SIGNED <b>11-23</b>			
22c. PHYSICIAN'S NAME (Type) <b>James G. Howell</b>				22d. ADDRESS <b>Catonsville</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/25/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>				ADDRESS <b>Catonsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 28 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12184

12227

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pikesville</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>4523 Old Court Road, Pikesville</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pikesville 8, Md.</b>	
f. STREET ADDRESS <b>4523 Old Court Road</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William G. Baxter</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>30</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1872</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Co., Md.</b>	
12. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. FATHER'S NAME <b>John Baxter</b>		15. MOTHER'S MAIDEN NAME <b>Salome Roth</b>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>	
18. INFORMANT <b>Mrs. Mamie E. Baxter</b>		Address <b>Pikesville 8, Md. 4523 Old Court Rd.</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
22. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		23. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		25. (City or town) (County) (State)	
26. I certify that (I) (this hospital) attended the deceased from <b>11-26-1960</b> to <b>11-30-1960</b> , that (I) (we) last saw the deceased alive on <b>11-30-1960</b> , and that death occurred at <b>11:55 PM</b> from the causes and on the date stated above.			
27a. SIGNATURE <b>George M. Ramapurnam M.D.</b>		27b. DATE SIGNED <b>DEC 5 '60</b>	
28a. PHYSICIAN'S NAME (Type) <b>George M. Ramapurnam M.D.</b>		28b. ADDRESS <b>3562 Croxdon Rd, Balt 7, Md</b>	
29a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		29b. DATE THEREOF <b>Dec. 3, 1960</b>	
29c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		29d. LOCATION (City, town, or county) (State) <b>Pikesville 8, Md.</b>	
30. FUNERAL DIRECTOR'S SIGNATURE <b>Frank A. Jewell</b>		31. ADDRESS <b>Pikesville 8</b>	
32a. REC'D BY REGISTRAR <b>DEC 5 '60</b>		32b. REGISTRAR'S SIGNATURE <b>Charles E. Kinner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13184

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

13222

Deceased

Sex

Age

Place of Birth

Name of Deceased

Place of Death

Date of Death

Time of Death

Cause of Death

Place of Burial

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of State Registrar

Signature of Federal Registrar

Signature of National Registrar

Signature of International Registrar

Signature of World Registrar

Signature of Universal Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>										
<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <b>MARYLAND</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>3V01-4</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ST. JOSEPH'S NURS. HOME</u>					d. STREET ADDRESS <u>5158 EDMONDSON AVE</u>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>NELLIE L. BECKER</u>					<b>4. DATE OF DEATH</b> Month Day Year <u>Nov. 22/60</u> <u>19</u>					
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 7, 1885</u>		9. AGE (In years lost birthday) <u>75</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>FERDINAND MANTLER.</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>MR. STANLEY BECKER, 5154 EDMONDSON AVE</u>			Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Failure</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Senile Change -</u> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Anemia - Carcinoma - Rectal - Adenoid.</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3</u> <u>1960</u> , to <u>11/22</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/22</u> 19 <u>60</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Victor F. King</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov 25, 60</u>			
22c. PHYSICIAN'S NAME (Type) <u>VICTOR F. KING</u>					22d. ADDRESS <u>Towson, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>NOV. 26/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE FUN. DIR. 4101 EDMONDSON AVE</u>					25a. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

39

1918

REPUBLIC OF CHINA

1918

15

15

15



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**12209** DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12186

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1726 Arlington Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lena M. Beckhusen</b>				4. DATE OF DEATH Month Day Year <b>Nov. 8, 1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 4, 1882</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B and O R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Louis C. Beckhusen</b>				14. MOTHER'S MAIDEN NAME <b>Lena Petzel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Emma T. Elliott 1726 Arlington Ave. #27</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast</b> DUE TO <b>General metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cholesterol obstruction</b> DUE TO <b>Myocardial clots</b> (c) <b>Myocardial clots</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma of skin (forehead)</b>							INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>2 mo</b> <b>2 mo</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 4, 1960</b> to <b>Nov 8, 1960</b> that (I) (we) last saw the deceased alive on <b>Nov 9, 1960</b> and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>B. Bruce Brumbaugh</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. Bruce Brumbaugh, M.D.</b>				22d. ADDRESS <b>5609 Main St. Elkridge, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/11/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Avenue</b>		25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12158

CERTIFICATE OF DEATH

12204

Baltimore

MD.

Baltimore

John

1725 ARNOLD AVENUE

John W. Beckman

John

white

male

born 1923

Retired

John Beckman

John W. Beckman

John W. Beckman

John W. Beckman

John W. Beckman

John W. Beckman

12210

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Halethorpe)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1014 Francis Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maisy</b> Middle <b>May</b> Last <b>Beitler</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>17</b> Hours <b>17</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Albert B. Carson</b>		14. MOTHER'S MAIDEN NAME <b>Ella Scheimer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Frederic Beitler</b>		Address <b>1014 Francis Ave. #27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Refractory Anemia</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Acute Lymphatic Leukemia</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 10, 1960</b> to <b>Nov 17, 1960</b> that I last saw the deceased alive on <b>Nov 17, 1960</b> and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James Howell</b> M.D.		ADDRESS (Street, city or town, state) <b>1011 Frederick Rd #28</b> DATE SIGNED <b>11-17</b>	
PHYSICIAN'S NAME (Type) <b>James Howell, M. D.</b>		<b>1011 Frederick Avenue #28</b> <b>11/17</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/21/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR <b>NOV 29 '60</b>	
ADDRESS <b>4107 Wilkens Avenue</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

12210

John J. Moore

John J. Moore (Name of Deceased)

114 Maple Avenue, 1011 Kansas Avenue

April 9, 1938

Married

Robert E. Carson

Miss Bohemer

Frederick Bohemer 1011 Kansas Ave.

12229

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12188

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8000 Lansdale Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>BEITZ</b> Last <b>BEITZ</b>		4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1887</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brewer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Don't know</b>		14. MOTHER'S MAIDEN NAME <b>Don't know</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Theresa Beitz</b>		Address <b>8000 Lansdale Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Embolism</b> 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Gangrene Right Foot</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>2 years</b> <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 8, 1960</b> to <b>Nov 12, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov 12, 1960</b> , and that death occurred at <b>11 M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Morris A. Jacobs M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>MORRIS A. JACOBS M.D.</b>		22d. ADDRESS <b>1010 NORTH Point Rd Balt 24 Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/16/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '60</b>	
ADDRESS <b>4210 Belair Road.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15183

RECEIVED

15530

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CHIEF

15



## 12230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowley's Quarters</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowley's Quarters</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 647 Rt. 14</b>			d. STREET ADDRESS <b>Box 647 Rt. 14</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Josiah</b> Middle <b>E.</b> Last <b>Biddison</b>			4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5, 1897</b>		9. AGE (In years last birthday) <b>62</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>County Highways</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Thomas A. Biddison</b>		
14. MOTHER'S MAIDEN NAME <b>Florence Earl</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>219-20-9516</b>			17. INFORMANT <b>Mr. George A. Biddison R.F.D. 14 Box 588 (20)</b>		
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A-S-C-U Disease</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No x</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>No x</b>	
20f. (City or town) <b>No x</b>		20g. (County) <b>No x</b>		20h. (State) <b>No x</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>M. B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/21/60</b>	
EXAMINER'S NAME (Type) <b>M. B. Davis M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-22-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Crem's Methodist</b>	
22d. LOCATION (City, town, or county) <b>Stemmers Run Balto. Co. Md.</b>		22e. (State) <b>Md.</b>		22f. (City or town) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Caroline Funeral Home</b>		ADDRESS <b>7401 Belton Rd</b>		24a. REC'D BY REGISTRAR <b>NOV 23 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12190

12200

1. PLACE OF DEATH a. COUNTY 8201 Boundary Rd. Balto. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE 8201 Boundary Rd. Balto. Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 3yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 8201 Boundary Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Margie May Black		4. DATE OF DEATH Month Day Year Nov. 27/60 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6.1885
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Lancaster Co. Pa.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Andrew Kane		14. MOTHER'S MAIDEN NAME Annie Klineyoung	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT James F. Black, 3641 Pulaski Hwy.		Address 24	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion A-S-C-V-DISEASE (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. Davis M.D.		DATE SIGNED 11/29/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 30/60	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Philip Henry Sons		24a. REC'D BY REGISTRAR DATE NOV 29 1960	
ADDRESS 2024 Orleans St. 31		24b. REGISTRAR'S SIGNATURE Wm. L. Thomas	

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12231

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth 4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>E.</b> Last <b>Blair</b>		4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7, 1878</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas O. Blair</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Bergen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 26, 19 60</b> , to <b>Nov. 30, 19 60</b> , that I last saw the deceased alive on <b>Nov. 30, 19 60</b> , and that death occurred at <b>4:35 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 11-30-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/3/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Travis Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Travis, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>	
ADDRESS <b>8728 Liberty Road</b>		DATE <b>DEC 7 '60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12232

12192

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>College Manor</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Chauncey</b> Middle <b>H</b> Last <b>Blodgett</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-23-1870</b>
9. AGE (In years lost birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pawtucket, R.I.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Winthrop Blodgett</b>		14. MOTHER'S MAIDEN NAME <b>Salome Kinsley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>A. Zeller R.N.</b> Address <b>College Manor</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>422.1</b> DUE TO <b>CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>arteriosclerosis</b> <b>myocarditis</b> DUE TO (b) <b>4</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1945</b> to <b>Nov 11, 1960</b> that (I) (we) last saw the deceased alive on <b>Nov 11, 1960</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>H. W. Jenkins</b>		22b. DATE SIGNED <b>11/12/60</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>1403 Park Ave Baltimore Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-14-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 16 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

CERTIFICATE OF DEATH

15233

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

12233

## CERTIFICATE OF DEATH

Reg. Dist. No.

1  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines, Catonsville, Md.</b>				d. STREET ADDRESS <b>15 D Maple Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry P. Boettcher</b>				4. DATE OF DEATH Month <b>November</b> Day <b>23</b> Year <b>19 60</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 19, 1879</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Augusta. Boettcher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>153-26-1074</b>		INFORMANT Address <b>Mrs. M. C. Hoxie, 15 D Maple Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Myocardial Decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chs. Hypertensive Cardiovascular Disease</b> lyng cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH <b>7da</b> <b>10-yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10-15-</b> , 19 <b>60</b> , to <b>11-23-</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11-22-</b> , 19 <b>60</b> , and that death occurred at <b>10</b> : <b>00</b> : <b>00</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm. K. Gallagher</b>				ADDRESS (Street, city or town, state) <b>6309 Frederick Ave. Baltimore - 28, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Wm. K. Gallagher, M.D.</b>				DATE SIGNED <b>11/23/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bayview</b>		22d. LOCATION (City, town, or county) (State) <b>Jersey City, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</b>				24a. REMOVAL BY REGISTRAR <b>NOV 28 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

12103

CERTIFICATE OF DEATH

12333

DATE OF DEATH

1900

PLACE OF DEATH

AT THE RESIDENCE OF THE DECEASED

CAUSE OF DEATH

AGE OF DECEASED

SEX

1

DATE OF BIRTH

1900

PLACE OF BIRTH

1900

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12234  
M  
12  
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2  
1  
BP

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12194

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>SIX-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood St. Tr. School</u>				d. STREET ADDRESS <u>Route 2 - Winfield Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Joseph</u> Last <u>Bosley</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/58</u>		9. AGE (In years lost birthday) yrs. <u>22</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allan Lindy Bosley</u>				14. MOTHER'S MAIDEN NAME <u>Aline Meek Mary Agnes Meek</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Rosewood Records</u>		Address <u>Owings Mills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive bleeding from peptic ulcer.</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Brain damage and mental retardation.</u> DUE TO (c) <u>Aspiration Pneumonia, right lower lobe.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>since birth</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/27/6</u> 19 <u>60</u> , to <u>11/15</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> 19 <u>60</u> , and that death occurred at <u>9:30 a.m.</u> the causes and on the date stated above.							
22a. SIGNATURE <u>Harry G. Butler</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11.16.60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>				22d. ADDRESS <u>Rosewood Lane, Owings Mills, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-17-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 21 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

15234

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Joseph's Nursing Home</b>					d. STREET ADDRESS <b>4900 Edmondson Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>William A. Brannan</b>					4. DATE OF DEATH <b>Nov. 24/60</b>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
6. SEX <b>M.</b>		7. COLOR OR RACE <b>W.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <b>June 23, 1874</b>		10. AGE (In years lost birthday) <b>86</b> yrs.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Brannan</b>	
14. MOTHER'S MAIDEN NAME <b>Jane Byrne</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Rev. Bernard A. Brannan</b>		17. INFORMANT <b>4900 Edmondson Ave</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia - Cardiac Failure</b> DUE TO <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>Senile Changes</b> DUE TO <b>Senile Changes</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
24. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		25. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		27. (City or town) (County) (State)		28. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.	
29. SIGNATURE <b>Victor F. King</b>		30. ATTENDING PHYS. <b>M.D.</b>		31. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		32. DATE SIGNED <b>11/25/60</b>		33. PHYSICIAN'S NAME (Type) <b>VICTOR F. KING</b>	
34. ADDRESS <b>1102 E. Joyce Rd Towson Md</b>		35. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		36. DATE THEREOF <b>Nov. 28/60</b>		37. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		38. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
39. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D.</b>		40. ADDRESS <b>4101 Edmondson Ave</b>		41. 25a. REC'D BY REGISTRAR <b>NOV 28 '60</b>		42. 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		43. 26. REGISTRAR'S SIGNATURE	

1919

MAINTAINING THE ORGANISM OF HEALTH  
CHARTERED BY THE U.S. DEPARTMENT OF HEALTH  
OFFICE OF THE U.S. DEPARTMENT OF HEALTH

1919

3

10

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12236

## CERTIFICATE OF DEATH

12196

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>3V01-4</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7726 Bagley Ave.</i>		d. STREET ADDRESS <i>1927 East 30th Street</i>	
3. NAME OF DECEASED (Type or print) First <i>Minnie</i> Middle <i>Breckel</i> Last <i>Breckel</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>15</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-28-1877</i>
9. AGE (In years last birthday) yrs. <i>83</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Breckel</i>		14. MOTHER'S MAIDEN NAME <i>Carrie Schaffer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Roy C. Hubbard</i>		Address <i>4623 Elstrode Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brachio Pneuonia</i> DUE TO <i>7-4-0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Fracture near left femur</i> DUE TO <i>33 days</i> (c) <i>Wolrus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>Fell at home</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell at home</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>9</i> p. m. <i>10-12</i> 19 <i>60</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Balto Md.</i>	
21. I certify that I attended the deceased from <i>1940</i> , 19 <i>60</i> , to <i>11-15</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>11-15-60</i> , 19 <i>60</i> , and that death occurred at <i>11:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. W. Peake</i>		DATE SIGNED <i>11-16-60</i>	
PHYSICIAN'S NAME (Type) <i>C. W. PEAKE</i>		ADDRESS (Street, city or town, state) <i>4508 Harford Road</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>11-19-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 17 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

TO HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

155336

15180

MD 204-10

1. DATE OF DEATH		2. PLACE OF DEATH		3. COUNTY	
JAN 10 1952		BALTIMORE		BALTIMORE	
4. NAME OF DECEASED		5. SEX		6. AGE	
JOHN J. BROWN		MALE		45	
7. OCCUPATION		8. MARITAL STATUS		9. RACE	
LABORER		MARRIED		WHITE	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. PLACE OF BIRTH	
HEART DISEASE		NATURAL		BALTIMORE	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signatures]	
16. DATE OF REGISTRATION		17. TIME OF REGISTRATION		18. OFFICE	
JAN 10 1952		10:00 AM		BALTIMORE	

FILED IN 11-11-52

NOTICE: This certificate is a legal document and must be filed in the proper office. It is the duty of the registrar to see that this certificate is properly filed and that the proper fees are paid. The registrar is also responsible for the distribution of this certificate to the proper authorities.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12237  
CERTIFICATE OF DEATH

12197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>lyrlmth20dys</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier, Maryland</u>		d. STREET ADDRESS <u>4009 - 35th Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>Peyton</u> Last <u>Breen</u>		4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1870</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Landram</u>		14. MOTHER'S MAIDEN NAME <u>Mary Downer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records : SPRING GROVE STATE HOSPITAL</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Cardiac failure</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 8, 1960</u> , to <u>Nov. 28, 1960</u> , that I last saw the deceased alive on <u>Nov. 28, 1960</u> , and that death occurred at <u>12:00pm</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslor</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>11-28-60</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslor, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Prince Georges</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u>		24a. REC'D BY REGISTRAR <u>DEC 1 1960</u>	
ADDRESS <u>Mt. Rainier, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>	







## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessup, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home, Catonsville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Lew</b> Last <b>Bruun</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1879</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>81</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Mrs. Geo. Mitchell, Box 161, Jessup, Md.</b>	
17. INFORMANT <b>Mrs. Geo. Mitchell, Box 161, Jessup, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Blindness, rt. eye; Prostatectomy, old; Gastric resection, old</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 14, 1958</b> , to <b>Nov. 9, 1960</b> , that I last saw the deceased alive on <b>Nov. 7, 1960</b> and that death occurred at <b>5:30 a. m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1303 Frederick R., Catonsville 28, Md.</b> DATE SIGNED <b>12/2/60</b>			
ACTUAL SIGNATURE <b>Wm. E. McGrath, M.D.</b>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>11/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Frank</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 5 '60</b>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1518

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

## CERTIFICATE OF DEATH

15248

PLACE OF DEATH		DATE OF DEATH	
HOME		JAN 10 1900	
CITY		BALTIMORE	
COUNTY		BALTIMORE	
STATE		MARYLAND	
AGE		65	
SEX		M	
RACE		W	
RELIGION		C	
EDUCATION		H	
OCCUPATION		C	
CAUSE OF DEATH		D	
MANNER OF DEATH		N	
PLACE OF BURIAL		C	
DATE OF BURIAL		JAN 10 1900	
CITY OF BURIAL		BALTIMORE	
COUNTY OF BURIAL		BALTIMORE	
STATE OF BURIAL		MARYLAND	
AGE AT BURIAL		65	
SEX AT BURIAL		M	
RACE AT BURIAL		W	
RELIGION AT BURIAL		C	
EDUCATION AT BURIAL		H	
OCCUPATION AT BURIAL		C	
CAUSE OF BURIAL		D	
MANNER OF BURIAL		N	
PLACE OF INTERMENT		C	
DATE OF INTERMENT		JAN 10 1900	
CITY OF INTERMENT		BALTIMORE	
COUNTY OF INTERMENT		BALTIMORE	
STATE OF INTERMENT		MARYLAND	
AGE AT INTERMENT		65	
SEX AT INTERMENT		M	
RACE AT INTERMENT		W	
RELIGION AT INTERMENT		C	
EDUCATION AT INTERMENT		H	
OCCUPATION AT INTERMENT		C	
CAUSE OF INTERMENT		D	
MANNER OF INTERMENT		N	
PLACE OF CREMATION		C	
DATE OF CREMATION		JAN 10 1900	
CITY OF CREMATION		BALTIMORE	
COUNTY OF CREMATION		BALTIMORE	
STATE OF CREMATION		MARYLAND	
AGE AT CREMATION		65	
SEX AT CREMATION		M	
RACE AT CREMATION		W	
RELIGION AT CREMATION		C	
EDUCATION AT CREMATION		H	
OCCUPATION AT CREMATION		C	
CAUSE OF CREMATION		D	
MANNER OF CREMATION		N	
PLACE OF EXHUMATION		C	
DATE OF EXHUMATION		JAN 10 1900	
CITY OF EXHUMATION		BALTIMORE	
COUNTY OF EXHUMATION		BALTIMORE	
STATE OF EXHUMATION		MARYLAND	
AGE AT EXHUMATION		65	
SEX AT EXHUMATION		M	
RACE AT EXHUMATION		W	
RELIGION AT EXHUMATION		C	
EDUCATION AT EXHUMATION		H	
OCCUPATION AT EXHUMATION		C	
CAUSE OF EXHUMATION		D	
MANNER OF EXHUMATION		N	
PLACE OF REINTERMENT		C	
DATE OF REINTERMENT		JAN 10 1900	
CITY OF REINTERMENT		BALTIMORE	
COUNTY OF REINTERMENT		BALTIMORE	
STATE OF REINTERMENT		MARYLAND	
AGE AT REINTERMENT		65	
SEX AT REINTERMENT		M	
RACE AT REINTERMENT		W	
RELIGION AT REINTERMENT		C	
EDUCATION AT REINTERMENT		H	
OCCUPATION AT REINTERMENT		C	
CAUSE OF REINTERMENT		D	
MANNER OF REINTERMENT		N	

TO 4051 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12239

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12199

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>13 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GROVER</b> Middle <b>C.</b> Last <b>BUCHANAN</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1887</b>
9. AGE (In years lost birthday) <b>73</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LUMBERMAN</b>	
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis Buchanan</b>		14. MOTHER'S MAIDEN NAME <b>Oliver Street</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>1-26-09/1-25-12</b>	
17. INFORMANT <b>CLIN REC</b>		Address <b>VAH BALTO 18 MD-FT HOWARD DIVISION</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS OBLITERANS, LEFT LEG</b> (c) <b>MARKED EMPHYSEMA OF LUNGS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>November 5, 1960</b> , to <b>November 18, 1960</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>November 18, 1960</b> , and that death occurred at <b>1:40</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Joshua A. Smith</b>		22b. DATE SIGNED <b>11-18-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSHUA A. SMITH</b>		22d. ADDRESS <b>VAH BALTO 18 MD - FT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-28/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward C. Tipton Funeral Home, HAMPSTEAD, MD.</b>		25a. RECEIVED BY REGISTRAR <b>NOV 28 60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

15110

CENTRAL OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
12240  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12200

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b> c. LENGTH OF STAY IN 1b <b>1 Day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3004 Virginia Avenue (15)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FRANK W. BUCHSBAUM</b> (Served as <b>FRANK W. BUCHSBAUM</b> )		4. DATE OF DEATH <b>November 4, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 16, 1877</b>
9. AGE (In years lost birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist's Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Buchsbaum</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Keyser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>S.A.W.</b>		16. SOCIAL SECURITY NO. <b>CLINICAL RECORDS, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>	
17. INFORMANT <b>CLINICAL RECORDS, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b> UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY EMPHYSEMA</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>November 3, 1960</b> , to <b>November 4, 1960</b> , that (X) (we) lost the deceased on <b>Nov. 4, 1960</b> , and that death occurred at <b>6:20 A.</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Frederick S. Donaldson</b> M.D.		22b. DATE <b>11/4/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18. MD., FORT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 8, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Vernon Lemmon</b>		25a. REC'D BY REGISTRAR <b>NOV 7 '60</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

12241  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12201

1. PLACE OF DEATH a. COUNTY <b>BALT.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHITE MARSH</b>		c. LENGTH OF STAY IN 1b <b>X WHITE MARSH</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VEROME AVE. BOX 860 BALTO. CO.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DAVID SAMUEL BUCKLEY</b>		4. DATE OF DEATH Month Day Year <b>NOV. 1 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 5 - 1877</b>
9. AGE (In years lost birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>B&amp;O RAILROAD</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>DAVID S BUCKLEY</b>		14. MOTHER'S MAIDEN NAME <b>LYDIA HILL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>RUTH BUCKLEY</b>		Address <b>SAME AS ABOVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 4201 DUE TO <b>Arteriosclerotic Cardio-Vascular disease 2 yrs</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 15 '60</b> to <b>Nov 1 '60</b> , that (I) (we) last saw the deceased alive on <b>Nov 1 '60</b> , and that death occurred at <b>4 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John G. Connolly</b>		22b. DATE SIGNED <b>11/2/60</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Baltob Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>NOV. 3, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BELAIR MEM.</b>		23d. LOCATION (City, town, or county) (State) <b>BELAIR MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connolly</b>		25a. REC'D BY REGISTRAR <b>Essex - Md</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>		DATE <b>NOV 4 '60</b>	

CERTIFICATE OF DEATH

1884

DATE

TIME

PLACE

WHITE MOUNTAIN

WOLF MOUNTAIN

REPORTED BY THE DOCTOR TO BE THE CAUSE OF DEATH

DAVID SAMUEL BUCKLEY

WHITE MOUNTAIN

WHITE MOUNTAIN

WHITE MOUNTAIN

WHITE MOUNTAIN

WHITE MOUNTAIN

WHITE MOUNTAIN

WHITE MOUNTAIN

CHILD 14111

1884

MADE IN U.S.A.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12202

12242

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1201 64th Street Zone 6</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>BUDDEMEYER</u> Last <u>BUDDEMEYER</u>				4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 11, 1883</u>	
9. AGE (In years last birthday) yrs. <u>77</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>  </u>							
13. FATHER'S NAME <u>George Fox</u>				14. MOTHER'S MAIDEN NAME <u>Anna Rassmussen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs Alvina Barrack</u> Address <u>1201 64th Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC C.V. DISEASE</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 Hours</u> <u>2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>  </u> , to <u>11/3/60</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>11/2/60</u> , 19 <u>  </u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>BENJ. B. MOSES, M.D.</u>				ADDRESS (Street, city or town, state) <u>448 N. Longview Ave. Balt.</u> DATE SIGNED <u>11/4/60</u>			
PHYSICIAN'S NAME (Type) <u>BENJ. B. MOSES, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 7, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly &amp; Zeiler Inc. 1901 Eastern Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b> d. STREET ADDRESS <b>607 Baltimore Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>SAMUEL</b>						4. DATE OF DEATH <b>November 7 19 60</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>25 March 1911</b>		9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Thomas N. Cain</b>						14. MOTHER'S MAIDEN NAME <b>Georgia Parker</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-26-9026</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease and Lung Abscess</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Therapeutic misadventure following thoracotomy</b>												INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Therapeutic misadventure</b>									
20c. TIME OF INJURY Month, Day, Year <b>8 a.m. 11/7/60</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Mt. Wilson</b> (County) <b>Balto.</b> (State) <b>Md.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/8/60</b>							
ACTUAL SIGNATURE <b>Charles S. Petty</b> EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>						Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Berkley Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Darlington Md.</b>							
23. FUNERAL DIRECTOR <b>Otelia P. Bullock, Harford County, Md.</b> ADDRESS <b>55th &amp; Erie St.</b>						24a. REC'D BY REGISTRAR <b>NOV 14 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					



[illegible]

THE STYLON 18 16



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
12244  
12204  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1205 Wakeford Circle</b>		d. STREET ADDRESS <b>1205 Wakeford Circle</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>E.</b> Last <b>CAKE</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>24</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1879</b>
9. AGE (In years lost birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-----</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sunbury, Pa.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Detrick</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Green</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>I</b>		16. SOCIAL SECURITY NO. <b>Burk Funeral Home-Northumberland, Pa.</b>	
17. INFORMANT <b>Burk Funeral Home-Northumberland, Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of descending colon</b> <b>153.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/15</b> 19 <b>60</b> to <b>11/24</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>11/24</b> 19 <b>60</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>E. Gordon Grau</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>E. GORDON GRAU</b>		22d. ADDRESS <b>8573 LOCH PAVEN BLVD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/28/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Westside Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Shamokin Dam, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekney</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 28 '60</b>	
ADDRESS <b>North + Palover #17</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Brown</b>	

1980



CERTIFICATE OF DEATH

15244



DATE OF DEATH  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12245

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12205

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr5mth20dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre deGrace, Maryland</b>			
d. STREET ADDRESS <b>608 Erie Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Maria</b> Middle <b>Calicchia</b> Last <b>Calicchia</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 2, 1886</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min.		IF UNDER 24 HRS. Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Italy</b>				12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>May 20, 1959</b> to <b>Nov. 10, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 10, 1960</b> , and that death occurred at <b>4:55</b> A. M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Stella Wachler</b>				22b. DATE SIGNED <b>11-10-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>			
23a. (BURIAL) CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Eain</b>		23d. LOCATION (City, town, or county) (State) <b>Harford Co., Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Prunty...</b>				25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

15245

DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK  
CERTIFICATE OF DEATH

15245

Blank certificate form with faint lines and text for recording death statistics.

TO HOSTEL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
4  
12246  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12206

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1 mth 2dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Alexander</b> Last <b>Campbell</b>		4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1877</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>01</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Race Track</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>263-16-3782</b> Informant <b>unknown</b> Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic mitral disease</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 30, 1960</b> to <b>Nov. 2, 1960</b> , that (I) (we) lost saw the deceased alive on <b>Nov. 2, 1960</b> , and that death occurred on <b>Nov. 2, 1960</b> at <b>8:00</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachler</b>		22b. DATE SIGNED <b>Nov. 3, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Nov. 5/60</b>		23b. DATE THEREOF <b>Nov. 5/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Pk</b>		23d. LOCATION (City, town, or county) (State) <b>Edisto, S. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witke F. P. 4101 Edmondson Ave</b>		25a. REC'D BY REGISTRAR <b>NOV 4 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

15208

CERTIFICATE OF DEATH

15246





1  
FOR STATE HEALTH DEPT. M  
X  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.  
VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**TITIAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Essex (21)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1641 "D" Eastern Ave.</b>		d. STREET ADDRESS <b>1641 "D" Eastern Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM M. CARROLL</b>		4. DATE OF DEATH <b>Nov. 4, 1960</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 27, 1895</b>	
9. AGE (In years last birthday) <b>65</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Agent</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Carroll Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Natalie Winecker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>138-20-7775A</b>		17. INFORMANT <b>Dorothy M. Carroll Same</b>	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-Vascular Disease</b> 443X DUE TO Condilions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>Disease</b> (c) <b>Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20f. (City or town) <b>Baltimore</b>		20g. (County) <b>Baltimore</b>		20h. (State) <b>Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. <b>M.B. DAVIS MD</b>		DATE SIGNED <b>11/5/60</b>	
EXAMINER'S NAME (Type) <b>M.B. DAVIS</b>		Address (Street, city, town, or county) <b>Baltimore, Md.</b>		22a. REC'D BY REGISTRAR <b>NOV 9 '60</b>	
22b. REMOVAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22c. DATE THEREOF <b>Nov. 7, 1960</b>		22d. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cemetery</b>	
22e. LOCATION (City, town, or country) <b>Balto. Co., Md.</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		22g. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	
23. FUNERAL DIRECTOR <b>James E. Bruzdinski</b>		ADDRESS <b>1407 Eastern Ave. #21</b>		24. REC'D BY REGISTRAR <b>NOV 9 '60</b>	
24a. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

1907

MISSOURI DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18846

FOR STATE  
RECORDS

*[Faint, mostly illegible text from the certificate form, including fields for name, age, sex, occupation, and cause of death.]*

TO HOSTEL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12248  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12208

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE Co</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE CITY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN 1b <b>24 years 9 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>514 THE SHEPPARD AND ENOCH PRATT HOSP</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM BENTON CARTER</b>		4. DATE OF DEATH <b>NOV. 9 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 2, 1990</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>9</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HENRY CARTER</b>		14. MOTHER'S MAIDEN NAME <b>SUSIE CARTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>HOSPITAL RECORDS.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420 -1</b> IMMEDIATE CAUSE (a) <b>Acute CORONARY Insufficiency.</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. } (b) <b>ARTERIOSCLEROTIC C.V.R Disease</b> (c) <b>Generalized Arteriosclerosis.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 years</b> <b>many years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 17 1936</b> , to <b>NOV. 9 1960</b> , that (I) (we) last saw the deceased alive on <b>NOV. 9 1960</b> , and that death occurred at <b>9:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry M. Murdock</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 12, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC.</b>		25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>	
ADDRESS <b>Baltimore Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	

1924

CERTIFICATE OF DEATH

THIS CERTIFICATE OF DEATH is hereby issued in accordance with the provisions of the Act of Congress, approved March 3, 1903, and amended April 15, 1904, and June 15, 1906, and the regulations thereunder, in the case of the death of

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]  
DATE OF REGISTRATION: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

12249  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
12249  
CERTIFICATE OF DEATH

12209

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chase</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 492, RFD 16,</b>		d. STREET ADDRESS <b>Box 492 RFD 16</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LILLIAN M. CAVANO</b>		4. DATE OF DEATH <b>November 15, 1960</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1896</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Scotland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Don't know</b>		14. MOTHER'S MAIDEN NAME <b>Don't know</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ellsworth Cavano Chase, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> DUE TO <b>170X CARCINOMA OF RIGHT BREAST</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>4 YRS.</b> (c) <b>4 YRS.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT 9, 1957</b> to <b>NOV. 15, 1960</b> , that (I) (we) last saw the deceased alive on <b>NOV. 15, 1960</b> , and that death occurred at <b>7:10 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Miceli</b> M.D.		22b. DATE SIGNED <b>11/18/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH MICELI M.D.</b>		22d. ADDRESS <b>108 S. TAYLOR AVE BALTO. 21 MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/18/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Dorsey, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 21 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>			

13304

INVESTIGATION OF DEPARTMENT OF JUSTICE  
UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

CONFIDENTIAL

13304

(M)

(1)



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>				c. LENGTH OF STAY IN 1b <b>53 Dundalk (22)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>23 Woodland Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>S.</b> Last <b>Cechotovsky</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24th</b> , Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19, 1891</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Black Smith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wendell Cechotovsky</b>				14. MOTHER'S MAIDEN NAME <b>Anna Procotsca</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-09-0576</b>		17. INFORMANT <b>Sadie S. Cechotovsky</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>A-S-C-V Disease</b> (c) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18. <b>None</b>					
20c. TIME OF INJURY Hour <b></b> o. m. <b></b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b></b>		(County) <b></b>	(State) <b></b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Melvin B. Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/25/60</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/29/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemty.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State) <b></b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>				24a. REC'D BY REGISTRAR <b>NOV 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DECEASED: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12310

NEWYORK STATE DEPARTMENT OF HEALTH - BATHING 18

# 12310 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED J. J. JONES		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH New York City		5. OCCUPATION Teacher		6. MARITAL STATUS Married	
7. DATE OF DEATH Jan 15, 1910		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER J. J. JONES	
13. SIGNATURE OF NEXT OF KIN J. J. JONES		14. SIGNATURE OF PHYSICIAN J. J. JONES		15. SIGNATURE OF CORONER J. J. JONES	
16. SIGNATURE OF JURY J. J. JONES		17. SIGNATURE OF WITNESSES J. J. JONES		18. SIGNATURE OF DECEASED J. J. JONES	
19. SIGNATURE OF DECEASED J. J. JONES		20. SIGNATURE OF DECEASED J. J. JONES		21. SIGNATURE OF DECEASED J. J. JONES	
22. SIGNATURE OF DECEASED J. J. JONES		23. SIGNATURE OF DECEASED J. J. JONES		24. SIGNATURE OF DECEASED J. J. JONES	
25. SIGNATURE OF DECEASED J. J. JONES		26. SIGNATURE OF DECEASED J. J. JONES		27. SIGNATURE OF DECEASED J. J. JONES	
28. SIGNATURE OF DECEASED J. J. JONES		29. SIGNATURE OF DECEASED J. J. JONES		30. SIGNATURE OF DECEASED J. J. JONES	
31. SIGNATURE OF DECEASED J. J. JONES		32. SIGNATURE OF DECEASED J. J. JONES		33. SIGNATURE OF DECEASED J. J. JONES	
34. SIGNATURE OF DECEASED J. J. JONES		35. SIGNATURE OF DECEASED J. J. JONES		36. SIGNATURE OF DECEASED J. J. JONES	
37. SIGNATURE OF DECEASED J. J. JONES		38. SIGNATURE OF DECEASED J. J. JONES		39. SIGNATURE OF DECEASED J. J. JONES	
40. SIGNATURE OF DECEASED J. J. JONES		41. SIGNATURE OF DECEASED J. J. JONES		42. SIGNATURE OF DECEASED J. J. JONES	
43. SIGNATURE OF DECEASED J. J. JONES		44. SIGNATURE OF DECEASED J. J. JONES		45. SIGNATURE OF DECEASED J. J. JONES	
46. SIGNATURE OF DECEASED J. J. JONES		47. SIGNATURE OF DECEASED J. J. JONES		48. SIGNATURE OF DECEASED J. J. JONES	
49. SIGNATURE OF DECEASED J. J. JONES		50. SIGNATURE OF DECEASED J. J. JONES		51. SIGNATURE OF DECEASED J. J. JONES	
52. SIGNATURE OF DECEASED J. J. JONES		53. SIGNATURE OF DECEASED J. J. JONES		54. SIGNATURE OF DECEASED J. J. JONES	
55. SIGNATURE OF DECEASED J. J. JONES		56. SIGNATURE OF DECEASED J. J. JONES		57. SIGNATURE OF DECEASED J. J. JONES	
58. SIGNATURE OF DECEASED J. J. JONES		59. SIGNATURE OF DECEASED J. J. JONES		60. SIGNATURE OF DECEASED J. J. JONES	
61. SIGNATURE OF DECEASED J. J. JONES		62. SIGNATURE OF DECEASED J. J. JONES		63. SIGNATURE OF DECEASED J. J. JONES	
64. SIGNATURE OF DECEASED J. J. JONES		65. SIGNATURE OF DECEASED J. J. JONES		66. SIGNATURE OF DECEASED J. J. JONES	
67. SIGNATURE OF DECEASED J. J. JONES		68. SIGNATURE OF DECEASED J. J. JONES		69. SIGNATURE OF DECEASED J. J. JONES	
70. SIGNATURE OF DECEASED J. J. JONES		71. SIGNATURE OF DECEASED J. J. JONES		72. SIGNATURE OF DECEASED J. J. JONES	
73. SIGNATURE OF DECEASED J. J. JONES		74. SIGNATURE OF DECEASED J. J. JONES		75. SIGNATURE OF DECEASED J. J. JONES	
76. SIGNATURE OF DECEASED J. J. JONES		77. SIGNATURE OF DECEASED J. J. JONES		78. SIGNATURE OF DECEASED J. J. JONES	
79. SIGNATURE OF DECEASED J. J. JONES		80. SIGNATURE OF DECEASED J. J. JONES		81. SIGNATURE OF DECEASED J. J. JONES	
82. SIGNATURE OF DECEASED J. J. JONES		83. SIGNATURE OF DECEASED J. J. JONES		84. SIGNATURE OF DECEASED J. J. JONES	
85. SIGNATURE OF DECEASED J. J. JONES		86. SIGNATURE OF DECEASED J. J. JONES		87. SIGNATURE OF DECEASED J. J. JONES	
88. SIGNATURE OF DECEASED J. J. JONES		89. SIGNATURE OF DECEASED J. J. JONES		90. SIGNATURE OF DECEASED J. J. JONES	
91. SIGNATURE OF DECEASED J. J. JONES		92. SIGNATURE OF DECEASED J. J. JONES		93. SIGNATURE OF DECEASED J. J. JONES	
94. SIGNATURE OF DECEASED J. J. JONES		95. SIGNATURE OF DECEASED J. J. JONES		96. SIGNATURE OF DECEASED J. J. JONES	
97. SIGNATURE OF DECEASED J. J. JONES		98. SIGNATURE OF DECEASED J. J. JONES		99. SIGNATURE OF DECEASED J. J. JONES	
100. SIGNATURE OF DECEASED J. J. JONES		101. SIGNATURE OF DECEASED J. J. JONES		102. SIGNATURE OF DECEASED J. J. JONES	

12310 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12250

## CERTIFICATE OF DEATH

12211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lodge Forest</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lodge Forest</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Res., 2113 Lodge Forest Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Maria</b> Middle <b>Eldzabeth</b> Last <b>Cederborg</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 26, 1880</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Sweden</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Sweden</b>							
13. FATHER'S NAME <b>Johan Lindbergh</b>				14. MOTHER'S MAIDEN NAME <b>Mathilda Anderson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Gustav A. Cederborg 2113 Lodge Forest</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Art. Sclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11.15</b> , 19 <b>60</b> , to <b>11.18</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11.17</b> , 19 <b>60</b> , and that death occurred at <b>11 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>520 D St. Balt 19 Md 11/20</b>							
ACTUAL SIGNATURE <b>R G WINDSOR</b> M.D. <b>520 D St. Balt 19 Md 11/20</b>							
PHYSICIAN'S NAME (Type) <b>R G WINDSOR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 21, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Eastern Ave. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA 7922 Wise Ave. 22, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12251 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
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MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armcast Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>VIRGINIA ANN CHEW</b>				4. DATE OF DEATH Month Day Year <b>November 1 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19, 1890</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>William Graf</b>				14. MOTHER'S MAIDEN NAME <b>Mathilda</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Howard W. Chew -1602 Regester Avenue #12</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO (b) <b>Asthmatic bronchitis</b> DUE TO (c) <b>SOIX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>10/15, 1958</b> to <b>11/1, 1960</b> that (I) (we) last saw the deceased alive on <b>11/1, 1960</b> and that death occurred at <b>11:28</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>E. Gordon</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>E. GORDON GRAU MD</b>				22d. ADDRESS <b>8523 Loch Raven Blvd</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/4/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tackner</b>				ADDRESS <b>Beth - 17, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 7 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>							



15318

CONTINUATION OF DEATH

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## CERTIFICATE OF DEATH

12213

Reg. Dist. No.

12252

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Balti.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8721 Loch Bend Dr.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Dorcas</i> Middle <i>E.</i> Last <i>Church</i>				4. DATE OF DEATH Month <i>Nov.</i> Day <i>1</i> Year <i>19 60</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 23, 1880</i>	
9. AGE (In years last birthday) <i>80</i> yrs.		10. KIND OF BUSINESS OR INDUSTRY <i>housewife</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Grant</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Vallie Church</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Arteriosclerosis</i> DUE TO (c) <i>Generalized Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>Years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 10, 1958</i> , to <i>Nov. 1, 1960</i> , that I last saw the deceased alive on <i>June 29, 1960</i> , and that death occurred at <i>5 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5101 Belair Road</i> DATE SIGNED <i>11/1/60</i>							
ACTUAL SIGNATURE <i>Charles V. Sevcik</i> M.D.				PHYSICIAN'S NAME (Type) <i>Charles V. Sevcik M.D. Baltimore E Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>11-5-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Birchwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Roxboro, N. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Rd.</i>				24a. REC'D BY REGISTRAR DATE <i>NOV 4 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1

12253

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12214

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco Rural</u>				c. LENGTH OF STAY IN 1b <u>5 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LEWIS - C - CLARK</u> First Middle Last				4. DATE OF DEATH <u>Nov 6 1960</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 10 - 1877</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ham Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Mrs Russell Buck - Upperco Md</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>002x Pulmonary Tuberculosis (Inactive)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1955</u> to <u>Nov 6 1960</u> , that (I) (we) last saw the deceased alive on <u>10/27 1960</u> , and that death occurred at <u>10 M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>W H Foward</u>				22b. DATE SIGNED <u>11-7-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>W H Foward M.D.</u>				22d. ADDRESS <u>Manchester Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 8 - 1960</u>		<u>all saints Epis.</u>		<u>Pleasanton Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Epton - Hampstead Md</u>				25a. REC'D BY REGISTRAR <u>NOV 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Foward</u>	

1831

CERTIFICATE OF DEATH

1833

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a formal record, possibly a death certificate or a similar official document, with various lines of text and some circular stamps or seals visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
12254  
CERTIFICATE OF DEATH

12215

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4yr3mth3dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Elizabeth</b> Last <b>Clark</b>		4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Boyer</b>		14. MOTHER'S MAIDEN NAME <b>Irene</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral vascular accident; old</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 7</b> to <b>Nov. 10, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 10</b> 19 <b>60</b> and that death occurred at <b>3:35</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b>		22b. DATE SIGNED <b>11-10-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-13-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		23d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stucky</b>		25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

12215

CERTIFICATE OF DEATH

12254

(4)

(1)





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
12255  
CERTIFICATE OF DEATH  
12216

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>		c. LENGTH OF STAY IN 1b <b>136 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WIRT</b> Middle <b>J.</b> Last <b>CLARK</b>		4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1897</b>
9. AGE (In years lost birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min. <b>63</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Loader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mines</b>	
11. BIRTHPLACE (State or foreign country) <b>Narrows, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>German Clark</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Blankenship</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>229-26-5856</b>	
17. INFORMANT <b>Clinical Records</b>		Address <b>VAH, Baltimore, Md - Fort Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, RIGHT UPPER LOBE</b> 502.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>EMPHYSEMA OF LUNGS, SEVERE, OBSTRUCTIVE</b> DUE TO (c) <b>ASTHMA, CHRONIC</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHITIS, CHRONIC. COR PULMONALE, CHRONIC</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 7, 1960</b> to <b>Nov. 20, 1960</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>Nov. 20, 1960</b> , and that death occurred at <b>9:20 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Frederick S. Donaldson</i>		22b. DATE <b>11/21/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD.FT. HOWARD DIV.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-23-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook-Blight, Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 28 1960</b>	
ADDRESS <b>6009 Harford Road Baltimore, Maryland</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12217

12256

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>15 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b> d. STREET ADDRESS <b>-- 14X-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <b>MARION</b> Middle <b>R.</b> Last <b>COLEMAN</b>			4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 4, 1878</b>		9. AGE (In years last birthday) <b>82</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fishing</b>		11. BIRTHPLACE (State or foreign country) <b>Chestertown, Maryland</b>	
13. FATHER'S NAME <b>James Coleman</b>			14. MOTHER'S MAIDEN NAME <b>Johanna Dickerson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 215-12-6245</b>		17. INFORMANT <b>Clinical Records VAH, Baltimore 18, Md. FORT HOWARD DIVISION</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> <b>600.0</b> DUE TO <b>PYELONEPHRITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE (b) TO URINARY RETENTION</b> <b>585X</b> <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b> <b>GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b> <b>UNKNOWN</b> <b>L MONTH</b> <b>UNKNOWN</b>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that ~~(x)~~ (this hospital) attended the deceased from **October 25, 1960** to **November 9, 1960**, that ~~(x)~~ (we) last saw the deceased alive on **November 9, 1960**, and that death occurred at **6:30** M, from the causes and on the date stated above.

22a. SIGNATURE <i>Frederick S. Donaldson</i>	M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>11/9/60</b>
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 12</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>	23d. LOCATION (City, town, or county) (State) <b>Rock Hill Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane</i>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 '60</b>	25b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

152518

DATE OF DEATH

1940

1940

NAME OF DECEASED

WILLIAM

AGE

40

SEX

MALE

RACE

WHITE

DATE OF BIRTH

1900

PLACE OF BIRTH

NEW YORK

EDUCATION

HIGH SCHOOL

OCCUPATION

LABORER

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

1940

PLACE OF DEATH

NEW YORK

EDUCATION

HIGH SCHOOL

OCCUPATION

LABORER

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

1940

PLACE OF DEATH

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

12257

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12218

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b> c. LENGTH OF STAY IN 1b <b>1 Day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton</b> d. STREET ADDRESS <b>26 Oakwood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>H.</b> Last <b>CONBOY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15th Oct. 1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>40</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Custom House</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Conboy</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>		18. ADDRESS <b>Baltimore 18, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> <b>NECROTIZING BRONCHIOLITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> (c) <b>EDEMA OF THE LUNGS, MODERATE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>UNKNOWN</b> <b>2 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (u) (this hospital) attended the deceased from <b>November 5, 1960</b> , to <b>November 6, 1960</b> , that (u) (we) lost saw the deceased alive on <b>November 6, 1960</b> , and that death occurred <b>1:40</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Frederick S. Donaldson</b>		22b. DATE <b>11/7/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>		22d. ADDRESS <b>VAH, Baltimore 18, Md. Fort Howard Div.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9th Nov. 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Odenton Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Richard V. Singleton</b>		25a. REC'D BY REGISTRAR <b>NOV 9 '60</b>	
ADDRESS <b>Glen Burnie, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



13318

CERTIFICATE OF DEATH

13318

Name of Deceased		John Edward Davidson	
Date of Birth		15 Nov. 1924	
Place of Birth		Chicago, Illinois	
Sex		Male	
Race		Caucasian	
Occupation		None	
Cause of Death		Heart Disease	
Date of Death		15 Nov. 1954	
Place of Death		Chicago, Illinois	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		15 Nov. 1954	
Place of Registration		Chicago, Illinois	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12219

12258

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN Tb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 TOWSON 4</b> d. STREET ADDRESS <b>1824 PROVIDENCE RD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>LIST</b> Middle <b>COTTON, SR.</b> Last		4. DATE OF DEATH <b>NOV</b> Month <b>13</b> Day <b>1960</b> Year			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-19-96</b>	9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MILL W. VA.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>MARTIN E. COTTON</b>		14. MOTHER'S MAIDEN NAME <b>BERTHA E. LIST</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>WIFE</b> Address <b>AS ABOVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRO-VASCULAR DISEASE</b>					INTERVAL BETWEEN ONSET AND DEATH: <b>1 MIN</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/13/60</b>	
EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY - <b>Gardens of Faith Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Baltimore County, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tickner &amp; Sons</b>		ADDRESS <b>Balto - 17, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 15 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>John S. Thomas</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 12259

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 24</u>		c. LENGTH OF STAY IN 1b <u>10 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7278 Gough St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM AMOS CRAMER</u>		4. DATE OF DEATH Month Day Year <u>November 22 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 7 1900</u>
9. AGE (In years last birthday) <u>60 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shopman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSIT CO.</u>	
13. FATHER'S NAME <u>Joseph H. CRAMER</u>		14. MOTHER'S MAIDEN NAME <u>Annie A. MARTIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-10-0115</u>	
17. INFORMANT <u>AGNES CRAMER</u>		Address <u>7278 Gough St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO (b) <u>Dehydration.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> to <u>Nov</u> , 19 <u>60</u> that I lost s/he the deceased alive on <u>Nov 10</u> , 19 <u>60</u> , and that death occurred at <u>2:45</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Leopoldo Gross</u> M.D. <u>405 Stemmers Pl. Rd. 11/2</u>			
PHYSICIAN'S NAME (Type) <u>Leopoldo Gross MD</u> <u>Baltimore 21, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-25-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Miller 2101 Medford Ave</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Claudia E. Miller</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)  
15M 9/5B

1838

NOTED AT THE TOWN OF ...

1838

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12260

CERTIFICATE OF DEATH

12221

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>2123 Homewood Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE W. CROMWELL</u>		4. DATE OF DEATH Month Day Year <u>November 12 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1895</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	
11. BIRTHPLACE (State or foreign country) <u>New Bedford, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Cromwell</u>		14. MOTHER'S MAIDEN NAME <u>Jane (MN: Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW 1</u>		16. SOCIAL SECURITY NO. <u>WW 1</u>	
17. INFORMANT <u>Clinical Records, VAH, Balto., Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA</u> DUE TO <u>162.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A.S.H.D.; Arteriosclerosis Generalized;</u> <u>Operations 10/20/60: Left Upper Lobe Tumor and Paralysis of left vocal</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>cord</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 26</u> <u>1960</u> , to <u>Nov. 12</u> <u>1960</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 12</u> <u>1960</u> , and that death occurred at <u>8:30</u> A. M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Joshua A. Smith</u>		22b. DATE SIGNED <u>11/12/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSHUA A. SMITH, M.D.</u>		22d. ADDRESS <u>VAH, Fort Howard, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/16/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u>		25a. REC'D BY REGISTRAR <u>NOV 14 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

1951

1951

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12222

12261

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marion</b> First <b>Crosby</b> Middle <b>Crosby</b> Last		4. DATE OF DEATH <b>Nov. 12</b> 19 <b>60</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1866</b>
9. AGE (In years last birthday) <b>94</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank I. Crosby</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Mrs. Cecil Cullon</b> Address <b>204 Dumbarton Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Semility</b> <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Advanced</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 11</b> , 19 <b>60</b> , to <b>Nov. 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Nov. 11</b> , 19 <b>60</b> , and that death occurred at <b>6:48</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Kingsville, Md.</b> DATE SIGNED <b>11-12-60</b>			
ACTUAL SIGNATURE <b>William A. Tyson</b>		PHYSICIAN'S NAME (Type) <b>William A. Tyson</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-14-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson, Inc., 1050 York Road, Towson</b>		24a. REC'D BY REGISTRAR <b>NOV 15 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>William S. Kenna</b>	



TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12223

12262

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>222 RIVERSIDE RD.</u>			d. STREET ADDRESS <u>1222 RIVERSIDE RD. (21)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>FERN</u> Last <u>DARRAH</u>			4. DATE OF DEATH Month <u>NOV.</u> Day <u>29</u> Year <u>1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-85</u>		9. AGE (In years lost birthday) <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEBRASKA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>AUGUST RACHOW</u>			14. MOTHER'S MAIDEN NAME <u>MINNIE ?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHN DARRAH (SAME AS ABOVE)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema and Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A.S.H.D. - Chronic Decompensation</u> DUE TO (c) <u>Generalized atherosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>60</u> , to <u>NOV. 23</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>NOV. 23</u> , 19 <u>60</u> , and that death occurred at <u>5P</u> M., from the causes and on the date stated above.					
22a. SIGNATURE <u>Joseph J. Cameron</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/1/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH J. CAMERON</u>		22d. ADDRESS <u>1515 - MARTIN BLVD - BALTO 20</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-2-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BELAIR MEM. GARDENS</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Connolly</u>		ADDRESS <u>418 Eastern Blvd. (21)</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 5 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

12224

Reg. Dist. No.

12263

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Baltimore</i> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> <span style="float: right;">b. COUNTY <i>Baltimore</i></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>			c. LENGTH OF STAY IN 1b <i>X</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9112 Crosshill Rd.</i>				d. STREET ADDRESS <i>9112 Crosshill Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Nellie</i> Middle <i>Grace</i> Last <i>Davies</i>				<b>4. DATE OF DEATH</b> Month <i>Nov.</i> Day <i>13</i> Year <i>19 60</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-7-1884</i>	
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Amos Davis</i>				14. MOTHER'S MAIDEN NAME <i>Sophia Davis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212032432</i>		17. INFORMANT <i>Raymond Davies</i>		Address <i>same</i>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-sclerotic Cardio Vascular Rhind Disease</i> <i>442 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>5 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>25 April</i> , 19 <i>49</i> , to <i>13 Nov</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>12 Nov</i> , 19 <i>60</i> , and that death occurred at <i>1030 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1614 Harford Rd. Baltimore, Md.</i> DATE SIGNED <i>Harford</i>							
ACTUAL SIGNATURE <i>Harford</i> M.D.							
PHYSICIAN'S NAME (Type) <i>Harford Goodman</i> <i>Stow-Cathedral Bldg. (14) Md</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>11-16-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 16 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







12264

12225

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>2 1/2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>EMRYS</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>11</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/31/1916</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>JOHN DAVIS</b>				14. MOTHER'S MAIDEN NAME <b>Lylean Richards</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-07-9288</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced Pulmo Tuberculosis.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11-11</b> 19 <b>60</b> , to <b>11-14</b> 19 <b>60</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11-14</b> 19 <b>60</b> , and that death occurred at <b>7:40 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>				22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/17/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. BURIAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>				25a. REC'D BY REGISTRAR <b>DATE NOV 18 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

BP



12226

12265

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <div>Baltimore</div>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <div>Maryland</div> <div>b. COUNTY</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div>Catonsville</div>		c. LENGTH OF STAY IN lb <div>6yr7mth5dys</div>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div>Baltimore</div> <div>3V01-4</div>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <div>SPRING GROVE STATE HOSPITAL</div>				d. STREET ADDRESS <div>2128 <del>XXXX</del> West Baltimore St.</div>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <div>Margaret</div>		First <div>H.</div>		Middle <div>Davis</div>	
Last <div></div>		4. DATE OF DEATH <div>November 22</div>		Month <div>19 60</div>	
5. SEX <div>female</div>		6. COLOR OR RACE <div>white</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> ? DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <div>1889 ?</div>		9. AGE (In years last birthday) <div>71</div> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div>housewife</div>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <div>Maryland</div>	
12. CITIZEN OF WHAT COUNTRY? <div>U. S. A.</div>		13. FATHER'S NAME <div>unknown</div>		14. MOTHER'S MAIDEN NAME <div>unknown</div>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <div>unknown</div>		16. SOCIAL SECURITY NO. <div>unknown</div>		17. INFORMANT <div>Records: SPRING GROVE STATE HOSPITAL</div>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div>Arteriosclerotic cardiovascular disease</div> 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <div>Generalized arteriosclerosis</div> DUE TO (c) <div></div>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <div>19</div>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <div></div>		(County) <div></div>		(State) <div></div>	
21. I certify that I attended the deceased from <div>Nov. 10</div> , 1960, to <div>Nov. 22</div> 19 60, that I last saw the deceased alive on <div>Nov. 22</div> , 19 60, and that death occurred at <div>1:40a</div> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <div>Stella Wachslor</div>		ADDRESS (Street, city or town, state) <div>SPRING GROVE STATE HOSPITAL</div>		DATE SIGNED <div>11-22-60</div>	
PHYSICIAN'S NAME (Type) <div>Stella Wachslor, M. D.</div>		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <div>Removal</div>		22b. DATE THEREOF <div>Nov. 25, 1960</div>		22c. NAME OF CEMETERY OR CREMATORY <div>St. Paul's Methodist Cem.</div>	
22d. LOCATION (City, town, or county) <div>Fawn Grove (York Co.) Penna.</div>		(State) <div></div>			
23. FUNERAL DIRECTOR'S SIGNATURE <div>William Cook, Inc.</div>		ADDRESS <div>1217 St. Paul Street</div>		24a. REC'D BY REGISTRAR <div>DATE NOV 28 '60</div>	
24b. REGISTRAR'S SIGNATURE <div>Carling L. Thomas</div>					

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
1SM 10/57



12267

## CERTIFICATE OF DEATH

12228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6737 Dogwood Rd.</u>				d. STREET ADDRESS <u>16737 Dogwood Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Maudie</u> Middle <u>De</u> Last <u>Greif</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 28, 1900</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Alfred Frizzell</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Ballinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Wm. White - 6737 Dogwood Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident -</u> <u>442X</u> DUE TO (b) <u>Hypertensive C.V. disease - renal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>insufficiency</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>APRIL 15</u> , 19 <u>58</u> , to <u>Nov. 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov. 11</u> , 19 <u>60</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>				ADDRESS (Street, city or town, state) <u>Randallstown - Md.</u>			
DATE SIGNED <u>11/11/60</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>11/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Randallstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury - 6411 Windsor M. H. Rd.</u>				ADDRESS <u>6411 Windsor M. H. Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Caroline E. Kenna</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1932

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED JAMES BROWN		2. SEX Male	
3. AGE 45		4. DATE OF DEATH Jan 15 1932	
5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease	
7. PLACE OF BIRTH Maryland		8. OCCUPATION Farmer	
9. MARITAL STATUS Married		10. EDUCATION High School	
11. RELIGION Roman Catholic		12. SIGNATURE OF DECEASED (if living)	
13. SIGNATURE OF WITNESSES J. B. Smith, M.D. J. C. Jones, M.D.		14. SIGNATURE OF REGISTRAR J. D. White	
15. SIGNATURE OF PHYSICIAN J. B. Smith, M.D.		16. SIGNATURE OF CLERK J. E. Black	
17. SIGNATURE OF CHURCH CLERK J. F. Green		18. SIGNATURE OF FUNERAL HOME J. H. Brown	
19. SIGNATURE OF BURIAL PLACE St. Mary's Church		20. SIGNATURE OF INTERVIEWER J. K. White	
21. SIGNATURE OF CORONER J. L. Black		22. SIGNATURE OF JURY J. M. White	
23. SIGNATURE OF JURY J. N. Black		24. SIGNATURE OF JURY J. O. White	
25. SIGNATURE OF JURY J. P. Black		26. SIGNATURE OF JURY J. Q. White	
27. SIGNATURE OF JURY J. R. Black		28. SIGNATURE OF JURY J. S. White	
29. SIGNATURE OF JURY J. T. Black		30. SIGNATURE OF JURY J. U. White	
31. SIGNATURE OF JURY J. V. Black		32. SIGNATURE OF JURY J. W. White	
33. SIGNATURE OF JURY J. X. Black		34. SIGNATURE OF JURY J. Y. White	
35. SIGNATURE OF JURY J. Z. Black		36. SIGNATURE OF JURY J. AA. White	
37. SIGNATURE OF JURY J. AB. Black		38. SIGNATURE OF JURY J. AC. White	
39. SIGNATURE OF JURY J. AD. Black		40. SIGNATURE OF JURY J. AE. White	
41. SIGNATURE OF JURY J. AF. Black		42. SIGNATURE OF JURY J. AG. White	
43. SIGNATURE OF JURY J. AH. Black		44. SIGNATURE OF JURY J. AI. White	
45. SIGNATURE OF JURY J. AJ. Black		46. SIGNATURE OF JURY J. AK. White	
47. SIGNATURE OF JURY J. AL. Black		48. SIGNATURE OF JURY J. AM. White	
49. SIGNATURE OF JURY J. AN. Black		50. SIGNATURE OF JURY J. AO. White	
51. SIGNATURE OF JURY J. AP. Black		52. SIGNATURE OF JURY J. AQ. White	
53. SIGNATURE OF JURY J. AR. Black		54. SIGNATURE OF JURY J. AS. White	
55. SIGNATURE OF JURY J. AT. Black		56. SIGNATURE OF JURY J. AU. White	
57. SIGNATURE OF JURY J. AV. Black		58. SIGNATURE OF JURY J. AW. White	
59. SIGNATURE OF JURY J. AX. Black		60. SIGNATURE OF JURY J. AY. White	
61. SIGNATURE OF JURY J. AZ. Black		62. SIGNATURE OF JURY J. BA. White	
63. SIGNATURE OF JURY J. BB. Black		64. SIGNATURE OF JURY J. BC. White	
65. SIGNATURE OF JURY J. BD. Black		66. SIGNATURE OF JURY J. BE. White	
67. SIGNATURE OF JURY J. BF. Black		68. SIGNATURE OF JURY J. BG. White	
69. SIGNATURE OF JURY J. BH. Black		70. SIGNATURE OF JURY J. BI. White	
71. SIGNATURE OF JURY J. BJ. Black		72. SIGNATURE OF JURY J. BK. White	
73. SIGNATURE OF JURY J. BL. Black		74. SIGNATURE OF JURY J. BM. White	
75. SIGNATURE OF JURY J. BN. Black		76. SIGNATURE OF JURY J. BO. White	
77. SIGNATURE OF JURY J. BP. Black		78. SIGNATURE OF JURY J. BQ. White	
79. SIGNATURE OF JURY J. BR. Black		80. SIGNATURE OF JURY J. BS. White	
81. SIGNATURE OF JURY J. BT. Black		82. SIGNATURE OF JURY J. BU. White	
83. SIGNATURE OF JURY J. BV. Black		84. SIGNATURE OF JURY J. BW. White	
85. SIGNATURE OF JURY J. BX. Black		86. SIGNATURE OF JURY J. BY. White	
87. SIGNATURE OF JURY J. BZ. Black		88. SIGNATURE OF JURY J. CA. White	
89. SIGNATURE OF JURY J. CB. Black		90. SIGNATURE OF JURY J. CC. White	
91. SIGNATURE OF JURY J. CD. Black		92. SIGNATURE OF JURY J. CE. White	
93. SIGNATURE OF JURY J. CF. Black		94. SIGNATURE OF JURY J. CG. White	
95. SIGNATURE OF JURY J. CH. Black		96. SIGNATURE OF JURY J. CI. White	
97. SIGNATURE OF JURY J. CJ. Black		98. SIGNATURE OF JURY J. CK. White	
99. SIGNATURE OF JURY J. CL. Black		100. SIGNATURE OF JURY J. CM. White	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

16 12268  
12229  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Zone 7</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1614 Forest Pk. Ave</u>		d. STREET ADDRESS <u>4918 Westhills Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Frederick L.</u> Middle <u>Hewberry</u> Last <u>Br</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16/95</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Essex Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick M. Hewberry</u>		14. MOTHER'S MAIDEN NAME <u>Julia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>213-03-9153</u>	
17. INFORMANT <u>Frederick L. Hewberry Jr.</u>		Address <u>753 Westhills</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>420</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE PULMONARY EDEMA</u> DUE TO (c) <u>ARTERIO-SCLEROTIC C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> 19 <u>57</u> to <u>11/11</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/11</u> 19 <u>60</u> , and that death occurred at <u>10:15 AM</u> on the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Shaw</u>		22b. DATE SIGNED <u>11/14/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D.</u>		22d. ADDRESS <u>5800 PENNSYLVANIA AVE. BALTIMORE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 15/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. 29. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witke F. H. 4101 Edmondson Ave</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 15 '60</u>	
ADDRESS <u>4101 Edmondson Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

15264

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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

12269

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>838 Milford Mill Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Evelyn</u> First <u>G. Diamond</u> Middle <u>G.</u> Last <u>Diamond</u>				4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>- - 1897</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Hermon Aaronson</u>				14. MOTHER'S MAIDEN NAME <u>Esther</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>Harry Diamond</u> Address <u>Same</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus, Arterial Hypertension</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>April 7, 1956</u> to <u>Nov. 1, 1960</u> , that I last saw the deceased alive on <u>Nov. 1, 1960</u> , and that death occurred at <u>8:57</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>MB Lewin</u>				ADDRESS (Street, city or town, state) <u>2186 University Parkway</u> DATE SIGNED <u>Nov 2, 1960</u>			
PHYSICIAN'S NAME (Type) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-3-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>		22d. LOCATION (City, town, or county) <u>Balto Md</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u> ADDRESS <u>2100 Center Place</u>				24a. REC'D BY REGISTRAR <u>NOV 3 '60</u> DATE <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• **BASES**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

12266  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12227

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		d. STREET ADDRESS <b>Owings Mills, Maryland</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Angela</b> Middle <b>DiFilippo</b> Last <b>DiFilippo</b>		4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1960</b>
9. AGE (In years lost birthday) yrs. <b>4</b> Months <b>2</b> Days <b>2</b> Hours <b>Min.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Berlin, Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Louis Lawrence DiFilippo</b>		14. MOTHER'S MAIDEN NAME <b>Marion Murphy Sanders</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Rosewood Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>hydrocephalus, cleft</b> DUE TO (c) <b>palate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Two</b> <b>Birth</b> <b>"</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/25</b> 19 <b>60</b> to <b>11/26</b> 19 <b>60</b> , that (I) (we) lost saw the deceased alive on <b>11/25</b> 19 <b>60</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry A. Butler M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-28-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City, town, or county) (State) <b>Wheaton Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 29 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>			

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WASH DC

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CERTIFICATE OF DEATH

1953

CHIEF OF POLICE

NEW YORK CITY



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12270 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12231

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Parkville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Johnny's Submarine Shop Corner YakOnna and Loch Raven</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Parkville</b> d. STREET ADDRESS <b>3014 Barclay Street-18</b>	
3. NAME OF DECEASED (Type or print) <b>JOANNE DOBBINS</b> First Middle Last 4. DATE OF DEATH <b>November 5 1960</b> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July-1927</b> 9. AGE (in years last birthday) <b>33</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Johnny's Sub Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>Wilkesbarre, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Nathan C. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Anna May Holter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mr. Eugene Dobbins-3014 Barclay St.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary artery thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D.	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/6/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/9/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Balto.</b>	
23. FUNERAL DIRECTOR <b>WIEDEFELD &amp; SON-Greenmount Ave &amp; 22nd</b>		24a. REC'D BY REGISTRAR <b>NOV 9 '60</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

THE STATE  
OF NEW YORK

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12570 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED	JOHN J. SMITH
AGE	45
SEX	Male
RACE	White
DATE OF DEATH	July 19, 1933
PLACE OF DEATH	Home, 1014 Barclay St., New York City
CAUSE OF DEATH	Myocardial Infarction
DETAILS OF DISEASE	Coronary artery atherosclerosis
DATE OF EXAMINATION	July 20, 1933
PLACE OF EXAMINATION	Home, 1014 Barclay St., New York City
SIGNATURE OF EXAMINER	William S. Petty
DATE OF SIGNATURE	12/5/33
PLACE OF SIGNATURE	204-Cornwall Ave & 32nd St., New York City

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12232

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>Baltimore 17</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House In The Pines</b>				d. STREET ADDRESS <b>Maryland</b> <b>3V01-4</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>B.</b> Last <b>DODSON, SR.</b>				4. DATE OF DEATH Month <b>November 25</b> Day <b>19</b> Year <b>60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1874</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months <b>86</b> Days	IF UNDER 24 HRS. Hours <b>86</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rubber Goods</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>C. Marion Dodson, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Malvina Bangs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-3954</b>		17. INFORMANT <b>Mrs. Bessie K. Dodson-824 Newington Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Decomposition</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1037</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-27-1960</b> to <b>11-25-1960</b> , that (I) <del>was</del> last saw the deceased alive on <b>11-24-1960</b> , and that death occurred at <b>6:20 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wilmer K. Gallagher</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher, M.D.</b>	
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS <b>6609 Frederick Ave., Baltimore 28, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-28-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickson</b>				25a. REC'D BY REGISTRAR <b>NOV 28 60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

**Baltimore - 17, Md.**

1897

CERTIFICATE OF DEATH

1897



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12233

12272

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>531 Regester Avenue</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b> d. STREET ADDRESS <b>531 Regester Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>M.</b> Last <b>DOST</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1872</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Charles Steinwedel</b>		14. MOTHER'S MAIDEN NAME <b>Hofmeister</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss M. Katherine Dost-531 Regester Avenue</b>		Address <b>Miss M. Katherine Dost-531 Regester Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>434-1</b> DUE TO (c) <b>434-1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>434-1</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> 19 <b>59</b> to <b>Nov.</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Nov. 9</b> 19 <b>60</b> and that death occurred at <b>2:15</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>W. M. Smith</b>		22b. DATE SIGNED <b>Nov. 14 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. M. Smith</b>		22d. ADDRESS <b>6305 Elm Alameda</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/12/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tucker</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1960</b>	
ADDRESS <b>Baltimore - 17, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Carroll S. Howard</b>	

13293

COMMITTEE OF WORK

13293

MEMORANDUM FOR THE COMMITTEE OF WORK  
SUBJECT: [Illegible]  
DATE: [Illegible]  
TO: [Illegible]  
FROM: [Illegible]  
[Several lines of illegible text follow]

*[Handwritten signature]*

*[Handwritten signature]*  
[Illegible text]  
[Illegible text]  
[Illegible text]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
ISM 9/59

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12273  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12234

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>32 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2542 Old Frederick Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNIE Dyson</b>		4. DATE OF DEATH Month <b>11</b> - Day <b>8</b> Year <b>1960</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 2, 1877</b>	
9. AGE (In years lost birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Clark</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Grace Phelps 2542 Old Frederick Road</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Melanoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>8-15</b> 19 <b>59</b> , to <b>11-8</b> 19 <b>60</b> , that (1) (we) last saw the deceased alive on <b>11-8</b> 19 <b>60</b> , and that death occurred at <b>11-8</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. Herbert, M.D.</b>		22b. DATE SIGNED <b>11-10-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D.</b>		22d. ADDRESS <b>Ellicott City, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/11/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 1960</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

65581



12274

CERTIFICATE OF DEATH

12235

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine J. Ehoff</b>		4. DATE OF DEATH Month Day Year <b>Nov. 24 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>ABOUT 3/4/87</b>
9. AGE (In years last birthday) <b>73 ? yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas Fitzgerald</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Green</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Clem E. Ehoff, 3039 W. Belvedere Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.2</b> DUE TO <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive heart disease arteriosclerosis</b> DUE TO (c) <b>Hypertensive heart disease arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>64 yrs</b> <b>1 mo</b> <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tuberculous adenitis, chronic</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 5</b> , 19 <b>54</b> , to <b>Nov 24</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Nov 24</b> , 19 <b>60</b> , and that death occurred at <b>6:30</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>3806 Fallstaff Road NOV 25 1960</b>			
ACTUAL SIGNATURE <b>Randolph H. Spitzberg</b>		M.D. <b>Baltimore 15, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Randolph H. Spitzberg, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/28/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Vernon Lemmon</b>		ADDRESS <b>4611 Park Heights, Balto. Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1908

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1908

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1908		Baltimore, Md.	
Cause of Death		Disease		Symptoms		Time of Death		Physician	
Heart Disease		Myocarditis		Chest Pain		10:00 AM		Dr. J. Smith	
Occupation		Education		Religion		Marital Status		Burial Place	
Teacher		High School		Catholic		Married		St. Mary's Church	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12275

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hosp</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type in print) First <u>Anne</u> Middle <u>A. E. K. D</u> Last <u>Ekas</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/3/81</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August clay</u>		14. MOTHER'S MAIDEN NAME <u>Henriette Sue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records Spring Grove State Hosp</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W.E. Mc Grath</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W.E. Mc Grath M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/24/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov, 28, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louson Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '60</u>	
ADDRESS <u>1217 St. Paul St.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	



1958

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1958

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. OCCUPATION [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]	
10. SIGNATURE OF MEDICAL EXAMINER [Faint text]		11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF CORONER [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF NEXT OF KIN [Faint text]		15. SIGNATURE OF BURIAL SOCIETY [Faint text]	
16. SIGNATURE OF FUNERAL HOME [Faint text]		17. SIGNATURE OF CHURCH [Faint text]		18. SIGNATURE OF CEMETERY [Faint text]	
19. SIGNATURE OF MINISTER [Faint text]		20. SIGNATURE OF RABBI [Faint text]		21. SIGNATURE OF PRIEST [Faint text]	
22. SIGNATURE OF BISHOP [Faint text]		23. SIGNATURE OF ARCHBISHOP [Faint text]		24. SIGNATURE OF PAPAL LEGATE [Faint text]	
25. SIGNATURE OF APOSTOLIC NUNCIUS [Faint text]		26. SIGNATURE OF VICE-LEGATE [Faint text]		27. SIGNATURE OF CHANCELLOR [Faint text]	
28. SIGNATURE OF SECRETARY [Faint text]		29. SIGNATURE OF CLERK [Faint text]		30. SIGNATURE OF RECORDS [Faint text]	
31. SIGNATURE OF ARCHIVE [Faint text]		32. SIGNATURE OF LIBRARY [Faint text]		33. SIGNATURE OF MUSEUM [Faint text]	
34. SIGNATURE OF GALLERY [Faint text]		35. SIGNATURE OF THEATRE [Faint text]		36. SIGNATURE OF CONCERT HALL [Faint text]	
37. SIGNATURE OF OPERA HOUSE [Faint text]		38. SIGNATURE OF CIRCUS [Faint text]		39. SIGNATURE OF CARNIVAL [Faint text]	
40. SIGNATURE OF FAIR [Faint text]		41. SIGNATURE OF EXHIBITION [Faint text]		42. SIGNATURE OF CONVENTION [Faint text]	
43. SIGNATURE OF MEETING [Faint text]		44. SIGNATURE OF CONFERENCE [Faint text]		45. SIGNATURE OF SYMPOSIUM [Faint text]	
46. SIGNATURE OF SEMINAR [Faint text]		47. SIGNATURE OF WORKSHOP [Faint text]		48. SIGNATURE OF SUMMIT [Faint text]	
49. SIGNATURE OF FORUM [Faint text]		50. SIGNATURE OF DEBATE [Faint text]		51. SIGNATURE OF PANEL [Faint text]	
52. SIGNATURE OF ROUND TABLE [Faint text]		53. SIGNATURE OF TOWN HALL [Faint text]		54. SIGNATURE OF COUNCIL [Faint text]	
55. SIGNATURE OF BOARD [Faint text]		56. SIGNATURE OF COMMITTEE [Faint text]		57. SIGNATURE OF SUBCOMMITTEE [Faint text]	
58. SIGNATURE OF JOINT COMMITTEE [Faint text]		59. SIGNATURE OF SELECT COMMITTEE [Faint text]		60. SIGNATURE OF SPECIAL COMMITTEE [Faint text]	
61. SIGNATURE OF AD HOC COMMITTEE [Faint text]		62. SIGNATURE OF TASK FORCE [Faint text]		63. SIGNATURE OF COMMISSION [Faint text]	
64. SIGNATURE OF BOARD OF ADVISORS [Faint text]		65. SIGNATURE OF BOARD OF CONSULTANTS [Faint text]		66. SIGNATURE OF BOARD OF SAGES [Faint text]	
67. SIGNATURE OF BOARD OF ELDERS [Faint text]		68. SIGNATURE OF BOARD OF SENIORS [Faint text]		69. SIGNATURE OF BOARD OF VETERANS [Faint text]	
70. SIGNATURE OF BOARD OF WARRIORS [Faint text]		71. SIGNATURE OF BOARD OF HEROES [Faint text]		72. SIGNATURE OF BOARD OF LEGENDS [Faint text]	
73. SIGNATURE OF BOARD OF MYTHS [Faint text]		74. SIGNATURE OF BOARD OF FABLES [Faint text]		75. SIGNATURE OF BOARD OF TALES [Faint text]	
76. SIGNATURE OF BOARD OF STORIES [Faint text]		77. SIGNATURE OF BOARD OF SONGS [Faint text]		78. SIGNATURE OF BOARD OF POEMS [Faint text]	
79. SIGNATURE OF BOARD OF PLAYS [Faint text]		80. SIGNATURE OF BOARD OF SCREENS [Faint text]		81. SIGNATURE OF BOARD OF STAGES [Faint text]	
82. SIGNATURE OF BOARD OF THEATRES [Faint text]		83. SIGNATURE OF BOARD OF CINEMAS [Faint text]		84. SIGNATURE OF BOARD OF STUDIOS [Faint text]	
85. SIGNATURE OF BOARD OF PRODUCTIONS [Faint text]		86. SIGNATURE OF BOARD OF DISTRIBUTION [Faint text]		87. SIGNATURE OF BOARD OF SALES [Faint text]	
88. SIGNATURE OF BOARD OF MARKETING [Faint text]		89. SIGNATURE OF BOARD OF PROMOTION [Faint text]		90. SIGNATURE OF BOARD OF ADVERTISING [Faint text]	
91. SIGNATURE OF BOARD OF PUBLICITY [Faint text]		92. SIGNATURE OF BOARD OF RELATIONS [Faint text]		93. SIGNATURE OF BOARD OF AFFAIRS [Faint text]	
94. SIGNATURE OF BOARD OF INTERAFFAIRS [Faint text]		95. SIGNATURE OF BOARD OF EXTERNAL AFFAIRS [Faint text]		96. SIGNATURE OF BOARD OF INTERNATIONAL AFFAIRS [Faint text]	
97. SIGNATURE OF BOARD OF DIPLOMACY [Faint text]		98. SIGNATURE OF BOARD OF POLITICAL AFFAIRS [Faint text]		99. SIGNATURE OF BOARD OF GOVERNMENT AFFAIRS [Faint text]	
100. SIGNATURE OF BOARD OF STATE AFFAIRS [Faint text]		101. SIGNATURE OF BOARD OF NATIONAL AFFAIRS [Faint text]		102. SIGNATURE OF BOARD OF INTERNATIONAL AFFAIRS [Faint text]	

1

2

3

4



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

12202  
12237  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dyndalk</b>		c. LENGTH OF STAY IN TB		d. STREET ADDRESS <b>7801 Gaywood Circle</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Died while at work on bus</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First Daniel E. Evans Middle David E. Evans Last Evans</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>14</b> Year <b>60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/10/07</b>		9. AGE (In years last birthday) <b>53</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Operatrpr</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto Transit</b>		11. BIRTHPLACE (State or foreign country) <b>Id</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George L Evans</b>				14. MOTHER'S MAIDEN NAME <b>Margaret McCormick</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT <b>Margaruite Evans 7801 Gaywood Circle</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4-20-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>DISEASE</b> (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>M30 avr</b> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Melvin B Davis 6800 Mornington</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>11/21/60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Burial Nov 17/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR <b>Ellsworth Armacost</b> Address (Street, city, town, or county) <b>4600 Liberty Hghts</b>				24a. REC'D BY REGISTRAR <b>NOV 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

Film G 279 - 1/17/61 - Two for one certificate -  
Original certificate signed by Dr. Benj. Berdanov destroyed.

Li 2-4414

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12276 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12239

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESASCO PK RURAL BALTO</b>		c. LENGTH OF STAY IN 1b <b>X CHESASCO PK *RURAL BALTO</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <b>305 Patansco Av</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EUGENE</b> Middle <b>GEORGE</b> Last <b>EVANS</b>			4. DATE OF DEATH Month <b>NOV</b> Day <b>11</b> Year <b>1960</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-2-26</b>	9. AGE (In years last birthday) <b>34</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>NORMAN C EVANS</b>			14. MOTHER'S MAIDEN NAME <b>EUGENIE BENA</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>219-22-5824</b>		17. INFORMANT Address <b>MR. NORMAN EVANS (SAME AS ABOVE)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GUNSHOT—RIGHT TEMPLE</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) <b>976X</b>					INTERVAL BETWEEN ONSET AND DEATH <b>INST</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DEPRESSION— From history</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted Gunshot</b>			
20c. TIME OF INJURY Month, Day, Year <b>Nov 11 1960</b> Hour <b>12:40</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	
20f. (City or town) <b>Balto rural</b>		20g. (County) <b>Balto</b>		20h. (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John C. Hyle</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11-11-60</b>	
EXAMINER'S NAME (Type) <b>John C Hyle</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-15-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL</b>	
22d. LOCATION (City, town, or county) <b>BALTO. MD.</b>		22e. (State) <b>MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John B. Connolly</b>		ADDRESS <b>418 Eastern Blvd. (21)</b>		24a. REC'D BY REGISTRAR <b>NOV 16 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G275 11-22-60 et

12203

CERTIFICATE OF DEATH

Reg. Dist. No.

12240

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 Admiral Blvd.		d. STREET ADDRESS 7 Admiral Blvd.					
3. NAME OF DECEASED (Type or print) First LEWIS		Middle EVANS		Last EVANS		4. DATE OF DEATH Month November 8 Day 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 8, 1887	
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roller		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Wales		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Evans				14. MOTHER'S MAIDEN NAME Elizabeth Foster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-09-0820		INFORMANT Dr. Eugene R. Evans 1 Liberty Pkwy.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.00 DUE TO Acute Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 10 MIN.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8, 1952 to Nov 8, 1960, that I last saw the deceased alive on Nov 8, 1960, and that death occurred at 8:30 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Lester Lebo		M.D.		ADDRESS (Street, city or town, state) 1801 Eulow Place		DATE SIGNED 11/9/60	
PHYSICIAN'S NAME (Type) LESTER LEBOWITZ							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.				24a. REC'D BY REGISTRAR NOV 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

12345

CENTRAL BANK OF AMERICA

12345

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove number papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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12277  
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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12241

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, 16 Fusting Ave.</b>		d. STREET ADDRESS <b>1636 Plymouth Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>S. Bernard Fitzpatrick</b>		4. DATE OF DEATH Month Day Year <b>Nov. 18/60</b> 19	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17, 1883</b>
9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Arundel Sand &amp; Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip J. Fitzpatrick</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Hubbard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>213 05 8491</b>	
17. INFORMANT <b>636 Plymouth Rd. Catonsville</b> <b>A---Mrs. Blanche Fitzpatrick</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the colon</b> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11/12, 1960</b> , to <b>11/18, 1960</b> , that (I) (we) last saw the deceased alive on <b>11/15, 1960</b> , and that death occurred at <b>2</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert A. Reiter</b>		22b. DATE <b>11/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert A. Reiter, M.D.</b>		22d. ADDRESS <b>3408 Windsor Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 21/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephen's Cem'ty</b>		23d. LOCATION (City, town, or county) (State) <b>Bradshaw, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D.</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1960</b>	
ADDRESS <b>4101 Edmondson Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Calvin S. Frank</b>	

*[Faint, illegible text from bleed-through]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

12278

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12242

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions, residence before admission) ✓ a. STATE <b>Maryland</b> b. COUNTY <b>X City</b> <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>10 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Middle River</b>	
4. DATE OF DEATH Month <b>11</b> Day <b>28</b> Year <b>1960</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Judy</b> Middle <b>Diane</b> Last <b>Florow</b>		4. DATE OF DEATH Month <b>11</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/20/55</b>	
9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Pearl Allan Florow</b>		14. MOTHER'S MAIDEN NAME <b>Loretta Wareheim, 71 Henderson Rd.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT Address <b>Rosewood Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>355X</b> DUE TO <b>Acute and chronic broncho-pneumonia, bilateral, extensive</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Brain damage</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/7</b> 19 <b>60</b> to <b>11/28</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>11/28</b> 19 <b>60</b> , and that death occurred at <b>8:30</b> P.M. the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. W. Rieckert</b>		22b. DATE SIGNED <b>11-29-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter W. Rieckert</b>		22d. ADDRESS <b>4307 Manfield Ave, Balto 14</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/30/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BEL AIR MEMORIAL GARDENS</b>		23d. LOCATION (City, town, or county) (State) <b>BEL AIR MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Chas F. Evans + Son</b>		25a. REC'D BY REGISTRAR <b>8802 Hartford Rd</b>	
25b. REGISTRAR'S SIGNATURE <b>DEC 1 '60</b>		25c. REGISTRAR'S SIGNATURE <b>6. Albert S. Kline</b>	

CERTIFICATE OF DEATH

1888

At the last of which I have been  
in the hands of the  
physician

at 10 West 4th St. N.Y.  
at 10 West 4th St. N.Y.

1888

## CERTIFICATE OF DEATH

12243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STEVENSON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STEVENSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VILLA JULIE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SISTER GERTRUDE d.u.s.c. (FORMEY)</b>		4. DATE OF DEATH Month Day Year <b>NOV. 17 1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 27, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>	
11. BIRTHPLACE (State or foreign country) <b>MASS.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>MATTHEW FORMEY</b>		14. MOTHER'S MAIDEN NAME <b>ANNA FITZIMMONS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>SISTER MARY PATRICK-VILLA JULIE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis.</b> <b>17.0X</b> DUE TO <b>Carcinoma of breast.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>18 Month</b> <b>6 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April</b> , 1959, to <b>Nov 17</b> , 1960, that I last saw the deceased alive on <b>Nov 10</b> , 1960, and that death occurred at <b>9:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Harold H Burns</b> M.D. <b>115 E. Cager St.</b> <b>11/18/60</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>11-29-60</b>	<b>Trinity Convent Cem.</b>	<b>Decheater, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Forley Cunningham F.H. - Catonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 28 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Rine</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15513

CERTIFICATE OF DEATH

15513

1

For examination

For review & signature

No. 10-60

Handwritten signature

Handwritten signature

Handwritten signature



12280

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>8409 Bel Air Rd #6</b>		c. LENGTH OF STAY IN 1b <b>XXXXX 1yr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Timonium</b>	
		d. STREET ADDRESS <b>2345 York Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>B.</b> Last <b>Fowler</b>		4. DATE OF DEATH Month <b>11</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-9-1873</b>
9. AGE (In years lost birthday) yrs. <b>87</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas H. Merryman</b>		14. MOTHER'S MAIDEN NAME <b>Martha Gerber</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>W. Leroy Merryman</b>		Address <b>2345 York Road Timmon</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>a Cerebral vascular stroke</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Uncl.</b> <b>5-6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 5</b> , 19 <b>60</b> , to <b>Nov 1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>28th October</b> , 19 <b>60</b> , and that death occurred at <b>2:40</b> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John C. Hyle</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>7527 Belair Rd Balto 6 11-2-60</b>	
PHYSICIAN'S NAME (Type) <b>JOHN C. Hyle</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-4-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Frederick Ave. Balto. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service Towson 4, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 3 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneave</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

1880

Baltimore, Maryland

2400 1st Ave. N.E. 11th St. Baltimore

1880-1881

John White, Male, 2-2-1880

U.S.A.

Martha Gordon

John White, Male, 2-2-1880

Martha Gordon

John White, Male, 2-2-1880

Martha Gordon

John White, Male, 2-2-1880

Martha Gordon

John White, Male, 2-2-1880

Martha Gordon

John White, Male, 2-2-1880

Martha Gordon

John White, Male, 2-2-1880

Martha Gordon

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12245

12281

Items 8, 16, 27, 11-14-60 et

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carrol Island</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt. 14 Box 571 Balto., 20 Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ABRAHAM</b> Middle <b>FOX</b> Last <b>FOX</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-19-1885/ 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Dolphin Co. Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Fox</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hummer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>162-22-2885</b>	
17. INFORMANT <b>Mr. Earl Fox</b>		Address <b>Rt. 14 Box 571 Balto., 20 Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>Nov.</b> , 1960, that (I) (we) last saw the deceased alive on <b>Oct.</b> , 1960, and that death occurred at <b>1 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Samuel Stern</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Samuel Stern, M.D.</b>		22d. ADDRESS <b>Ridge Rd. Baltimore 6 Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-9-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Shoops Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Dolphin Co. Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Fun'l Home</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 9 '60</b>	
ADDRESS <b>7401 Belair Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1000

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

STATE OF TEXAS

18581



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "X" and "18581" are visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

12214

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12246

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bella</i>		c. LENGTH OF STAY IN 1b <i>1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bella, Elliott City P.O.</i>	
d. STREET ADDRESS <i>Bella, Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Harry</i> First <i>France</i> Middle Last		4. DATE OF DEATH Month <i>Nov.</i> Day <i>20</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/14/80</i>
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rubber Worker Mill-Ret.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Theodore France</i>		14. MOTHER'S MAIDEN NAME <i>Christina Imhoff</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-09-6246</i>	
17. INFORMANT <i>WALTER FRANCE</i> Address <i>Family Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>11/17/60</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>11/17/60</i> <i>11/20/60</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>11/17/60</i> to <i>11/20/60</i> , that (I) (we) last saw the deceased alive on <i>11/17/60</i> and that death occurred at <i>2:15 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>W. E. McGraw</i>		22b. DATE <i>11/21/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. E. McGraw MD.</i>		22d. ADDRESS <i>1303 Frederick Rd (28) Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/23/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns</i>		23d. LOCATION (City, town, or county) (State) <i>Howard Co. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>McGraw &amp; Son Co. 28</i>		25a. REGISTERED BY REGISTRAR DATE <i>NOV 28 60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>			





12282

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>51yr11mth28dys</u> <u>Jerusalem, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>none</u> <u>12X-2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>(Volker)</u> Last <u>Fulker</u>				4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 10, 1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Russia</u>							
13. FATHER'S NAME <u>Philip Volker</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>Nov. 16, 1960</u> to <u>Nov. 29, 1960</u> , that I last saw the deceased alive on <u>Nov. 29, 1960</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>11-29-60</u>							
ACTUAL SIGNATURE <u>Stella Wachsler</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-1-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Christian Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harford County, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
12283 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12248										
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point 19</b> c. LENGTH OF STAY IN 1b <b>19</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2901 Orth Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point 19</b> d. STREET ADDRESS <b>2901 Orth Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JAMES LOUIS FUNDERBURK</b>					4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19, 1960</b>		9. AGE (In years last birthday) <b>4</b> IF UNDER 1 YEAR: Months <b>3</b> Days <b>3</b> IF UNDER 24 HRS.: Hours <b>3</b> Min. <b>3</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-----</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Funderburk</b>					14. MOTHER'S MAIDEN NAME <b>Lucille Bailey</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-----</b>					16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Lucille B. Funderburk - 2901 Orth Road</b>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis</b> DUE TO <b>492X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-----</b> DUE TO (c) <b>-----</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>										INTERVAL BETWEEN ONSET AND DEATH <b>-----</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour <b>19</b> a.m. <b>-----</b> p.m. <b>-----</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>		20g. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>		20h. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/22/60</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-23-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		22d. LOCATION (City, town, or country) <b>Baltimore, Maryland</b>		22e. (State) <b>-----</b>		22f. (State) <b>-----</b>
23. FUNERAL DIRECTOR <b>Charles R. Law 802 Madison Avenue</b>					24a. REC'D BY REGISTRAR <b>NOV 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>			24c. (State) <b>-----</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12249

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b> c. LENGTH OF STAY IN 1b <b>105 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (6)</b> d. STREET ADDRESS <b>1206 Sixty-second Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>J.</b> Last <b>GAFF</b>		4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 14, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b>10</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor of Laborers</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Gaff</b>		14. MOTHER'S MAIDEN NAME <b>Marion Sullins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>VAH, Baltimore 18, Md. FORT HOWARD DIVISION</b>	
17. INFORMANT <b>Clinical Records</b> Address <b>VAH, Baltimore 18, Md. FORT HOWARD DIVISION</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA, UPPER LOBE OF LEFT LUNG</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>EDEMA OF LUNGS</b> DUE TO (c) <b>HYPERTROPHY AND DILATATION OF HEART WITH ARTERIOSCLEROSIS OF THE AORTIC AND MITRAL VALVES</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>1 DAY</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>August 15, 1960</b> , to <b>November 28, 1960</b> , that (a) (we) last saw the deceased alive on <b>Nov. 28/60</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Fredrick S. Donaldson</b> 22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>		22b. DATE SIGNED <b>11/28/60</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>December 1/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herwig, Sons</b>		25a. REC'D BY REGISTRAR <b>NOV 29 '60</b>	
ADDRESS <b>2024 Orleans Street Baltimore, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>William K. Brown</b>	



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CERTIFICATE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12215**  
**CERTIFICATE OF DEATH**

12250

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>				c. LENGTH OF STAY IN 1b <b>Reisterstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cockeysmill Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary Catherine Gamber</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>27,</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1909</b>		9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Hoffman</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Eyler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-24-0170</b>		17. INFORMANT <b>Mr. John H. Gamber</b> Address <b>Reisterstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>722.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anemia - secondary</b> DUE TO (c) <b>Arthritis - rheumatoid - severe</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>2 months</b> <b>12 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 16, 1953</b> , to <b>November 27, 1960</b> , that I last saw the deceased alive on <b>November 27, 1960</b> , and that death occurred at <b>11:50 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clarence E. McWilliams</b>				ADDRESS (Street, city or town, state) <b>1194 Reisterstown Rd, Reisterstown, Md.</b> DATE SIGNED <b>Nov 27/1960</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 30, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons</b>				ADDRESS <b>Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 29 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																													
12285					CERTIFICATE OF DEATH					12251																			
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)																			
a. COUNTY					BALTO. MARYLAND					o. STATE					MD. b. COUNTY					BALTO.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					CATONSVILLE					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					SD CATONSVILLE									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					3 N. ROLLING RD					d. STREET ADDRESS					1 3 N. ROLLING RD					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					JOHN M. GASKE SR.					4. DATE OF DEATH					NOV. 2 1960														
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		DEC. 27, 1898		67 yrs.		Months		Days		Hours		Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?														
PRESIDENT					PUBLISHING CO.					MD.																			
13. FATHER'S NAME					MICHAEL GASKE					14. MOTHER'S MAIDEN NAME					MARY ANN														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					INFORMANT					Address														
NO										Mrs John M. Gaske - 3 N Rolling Rd.																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										metastatic Ca of 2nd										2 yrs									
154X DUE TO										Carcinoma of Rectum																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) DUE TO										(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																								
20c. TIME OF INJURY					20d. INJURY OCCURRED					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town)					(County)					(State)				
Month, Day, Year					While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>																								
Hour o. m. p. m.					19																								
21. I certify that I attended the deceased from May 1942 to Nov 2, 1960, that I last saw the deceased alive on Nov 2, 1960, and that death occurred at 8 A. M. from the causes and on the date stated above.																													
ACTUAL SIGNATURE										ADDRESS (Street, city or town, state)										DATE SIGNED									
J. C. Pound										MD 3325 Frederick Ave										11/4/60									
PHYSICIAN'S NAME (Type)																													
22a. BURIAL, CREMATION, REMOVAL (Specify)					22b. DATE THEREOF					22c. NAME OF CEMETERY OR CREMATORY					22d. LOCATION (City, town, or county)					(State)									
Burial					11-5-60					Cathedral Am.					Balt.					MD.									
23. FUNERAL DIRECTOR'S SIGNATURE										ADDRESS										24a. REC'D BY REGISTRAR					24b. REGISTRAR'S SIGNATURE				
Foley-Caraway Funeral Home-Catonsville, Md.																				DATE NOV 9 '60					Arthur L. Kraus				

CERTIFICATE OF DEATH

12382

12381

STATE OF NEW YORK

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12252

12286

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>			
c. LENGTH OF STAY IN 1b <u>3 days</u>				d. STREET ADDRESS <u>BFD 2 Box 110</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
<u>FRANCIS</u>		<u>B.</u>		<u>GAVIN</u>			
4. DATE OF DEATH		Month		Day		Year	
<u>November</u>		<u>5</u>		<u>1960</u>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>Oct. 5, 1917</u>		<u>43</u> yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Letter Carrier</u>		<u>U.S. Government</u>		<u>Baltimore, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Gavin</u>				14. MOTHER'S MAIDEN NAME <u>Mary S. Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
<u>Yes</u> <u>Korean</u>		<u>219-05-1647</u>		<u>Clinical Records, VAH, Baltimore 18, Md.</u> <u>FORT HOWARD DIVISION</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. BRONCHOGENIC CARCINOMA RIGHT LUNG WITH METASTASIS</u> <u>TO LEFT LUNG, LEFT ADRENAL T2 AND T3 WITH</u> <u>COMPRESSION OF THE SPINAL CORD AND RIGHT</u> <u>BRANCHIAL PLEXUS</u> <u>2. EDEMA OF THE LUNGS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u> <u>2 DAYS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 2</u> <u>1960</u> to <u>Nov. 5</u> <u>1960</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 5</u> <u>1960</u> , and that death occurred at <u>P.</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Ernest O. Brown</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11-6-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>ERNEST O. BROWN</u>				22d. ADDRESS <u>VAH Baltimore 18 Md- Ft Howard Division</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-9-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H Newell Inc</u>				25a. REC'D BY REGISTRAR <u>Reisterstown Rd &amp; Waldron Ave</u> <u>Baltimore, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kins</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13708

CERTIFICATE OF DEATH

1924

State of New York  
County of New York  
City of New York  
I, the undersigned, being a duly qualified Medical Officer of Health for the City and County of New York, do hereby certify that on the \_\_\_\_\_ day of \_\_\_\_\_, 1924, at \_\_\_\_\_, New York, the body of \_\_\_\_\_, of the age of \_\_\_\_\_ years, was found dead, and that the cause of death was \_\_\_\_\_, and that the death was due to natural causes.

Witness my hand and the seal of the City and County of New York, this \_\_\_\_\_ day of \_\_\_\_\_, 1924.  
\_\_\_\_\_  
Medical Officer of Health

Attest:  
\_\_\_\_\_  
City Clerk



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12287

CERTIFICATE OF DEATH

12253

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>8 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Presbyterian Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>207 W. 29th St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>May Esler Glass</b>		4. DATE OF DEATH <b>November 9 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David Wilson Glass</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Ann Graham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. T.E. Elliott, Supt. Presbyterian Home</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY OCCLUSION</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>VRS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 1958</b> to <b>NOV 9 1960</b> , that (I) (we) last saw the deceased alive on <b>NOV 9 1960</b> , and that death occurred at <b>8:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur S. Thoms</b>		22b. DATE SIGNED <b>11-11-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. S.J. Venable, JR.</b>		22d. ADDRESS <b>7215 York Road, Towson MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 12, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Place</b>		25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>			

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CERTIFICATE OF DEATH

15287

Blank form with horizontal lines for text entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

VP A15 (4)  
15M 9/59

12288

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12254

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>24 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Anna</b>			4. DATE OF DEATH <b>Nov</b> Month <b>Nov</b> Day <b>26</b> Year <b>1960</b>		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 23, 1887</b>		9. AGE (In years lost birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>			16. SOCIAL SECURITY NO. <b>unknown</b>		
17. INFORMANT <b>Mrs Joseph Hartnett</b> Address <b>1109 Kevin Rd.</b>			Records: <b>SPRING GROVE STATE HOSPITAL</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Syncope</b> DUE TO <b>157X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>CARCINOMA OF PANCREAS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While o. m. p. m. <input type="checkbox"/> Not while o. m. p. m. <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 2, 1960</b> to <b>Nov 26, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov 26, 1960</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Blanca Gimenez</b>			22b. DATE SIGNED <b>Nov 27/60</b>		
22c. PHYSICIAN'S NAME (Type) <b>Blanca Gimenez</b>			22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 30/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemy</b>	
23d. LOCATION (City, town, or county) <b>Balto. Md.</b>		(State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Fun. Dir. 4101 Edmondson Ave.</b>			25a. REC'D BY REGISTRAR <b>NOV 28 '60</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Klaus</b>					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

12255

12289

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>7 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b>		e. STREET ADDRESS <b>102 Bloomsbury Ave.,</b>	
3. NAME OF DECEASED (Type or print) <b>Annie</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>26,</b> Year <b>1960.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1868</b>
9. AGE (In years last birthday) <b>92 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Philip Gress</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Irene M. Ring</b> Address <b>102 Bloomsbury Ave. (28)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia Relatinal Senile</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac failure</b> (b) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 12, 1953</b> , to <b>Nov 26, 1960</b> , that I last saw the deceased alive on <b>Nov 21, 1960</b> , and that death occurred at <b>10:55 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Cliff Ratcliff</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>4605 EDMONDSON AVE 11/27/60</b>	
PHYSICIAN'S NAME (Type) <b>CLIFF RATCLIFF, JR.</b>		<b>BALTIMORE 19, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-28-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. Howard Strong</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 29 '60</b>	
ADDRESS <b>3707 W. North Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15289

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12256

12290

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balti.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> <u>SS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>550 HAMPTON RD</u>		d. STREET ADDRESS <u>550 HAMPTON RD</u> <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY E GOTTSCHALL</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MANUFACTURER</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles F. Gottschall</u>		14. MOTHER'S MAIDEN NAME <u>Louise Steidle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>164-09-0302</u>	
17. INFORMANT <u>Mrs Kathryn M. Gottschall</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>9/25, 1956</u> to <u>11-4, 1960</u> , that I last saw the deceased alive on <u>10-5, 1960</u> , and that death occurred at <u>3:11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Anthony F. Carozza</u> M.D.		ADDRESS (Street, city or town, state) <u>5217 YORK RD. BALTO 12 MD</u> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>ANTHONY F. CAROZZA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov 7-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Charles Baber Cemetery</u>	22d. LOCATION (City, town, or county) <u>Potterville</u> (State) <u>PA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shirley F. Leitz</u>		24. REC'D BY REGISTRAR DATE <u>NOV 7 '60</u>	
ADDRESS <u>5209 YORK RD BALTIMORE 12 MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

12345

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TO DECEASED: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12291 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradshaw</u>	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradshaw</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belgium Village Rt. 40</u>		d. STREET ADDRESS <u>Belgium Village Rt. 40</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Clayton</u> First <u>Lee</u> Middle <u>Grabill</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1913</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laboring</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Robert Grabill</u>	
14. MOTHER'S MAIDEN NAME <u>Angie Estelle Long</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Naomi F. Rose</u> Address <u>4503 Newton St. Mt. Rainer, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary BCC</u> <u>420.1</u> DUE TO <u>Coronary Heart dis</u> Conditions, if any, which gave rise to immediate cause (b) <u>5 yrs</u> (c) <u>Diabetes Mellitus</u> DUE TO <u>5 yrs</u> causing the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-6-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Massanuttes Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodstock Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lester H. Smith</u> Address <u>Home 2401 Belvoir Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



12292

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT HOME</u>		d. STREET ADDRESS <u>1736 Frederick Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>M.</u> Last <u>GRADY</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BATONSVILLE Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MILLER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET HARNICH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>MR. HARRY A. BILLINGS</u>		Address <u>736 Fred. Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arterio sclerotic Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>  </u> DUE TO <u>Generalized Arteriosclerosis</u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/25/60</u> to <u>11/25/60</u> , that I last saw the deceased alive on <u>11/25/60</u> , 19 <u>  </u> , and that death occurred at <u>555 P.</u> M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd</u> DATE SIGNED <u>11/27/60</u>	
ACTUAL SIGNATURE <u>W. E. McGrath</u> M.D.			
PHYSICIAN'S NAME (Type) <u>W. E. McGrath MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 28, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. TRUMAN SCHWAB</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1938

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>	
DATE OF DEATH <i>Jan 15 1938</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Teacher</i>		EDUCATION <i>High School</i>	
RESIDENCE <i>123 Main St, Baltimore, Md</i>		BIRTH <i>Jan 15 1893</i>		PLACE OF BIRTH <i>Maryland</i>	
FATHER'S NAME <i>John Doe</i>		MOTHER'S NAME <i>Jane Doe</i>		MARRIAGE <i>Married</i>	
PREVIOUS ILLNESS <i>None</i>		TREATMENT <i>None</i>		HISTORY <i>None</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>	
DATE OF SIGNATURE <i>Jan 15 1938</i>		DATE OF SIGNATURE <i>Jan 15 1938</i>		DATE OF SIGNATURE <i>Jan 15 1938</i>	

ADDITIONAL INFORMATION  
BIOGRAPHICAL SKETCH  
EDUCATION  
MARRIAGE  
CHILDREN  
MILITARY SERVICE  
AWARDS  
HONORS  
RELIGIOUS AFFILIATION  
POLITICAL AFFILIATION  
SOCIAL AFFILIATION  
OCCUPATIONAL HISTORY  
FAMILY HISTORY  
GENEALOGY  
ANCESTRY  
DESCENDANTS  
OTHER INFORMATION

REMARKS  
This is to certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland.  
WITNESSED AND SUBSCRIBED AT BALTIMORE, MARYLAND, this 15th day of January, 1938.  
J. Edgar Hoover  
Director



12293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr5mth9dys</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. STREET ADDRESS <b>5316 - 59th Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Grasso</b> Last <b>Grasso</b>				4. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1885?</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b>		IF UNDER 24 HRS. Hours <b>11</b> Min. <b>1960</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Florist helper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Florist</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Rosario Grasso</b>				14. MOTHER'S MAIDEN NAME <b>Josephine ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction myocardial failure</b> DUE TO <b>Arteriosclerosis Cardio vascular disease</b> <b>Generalized 11/14/60/arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture right hip accident</b> (c) <b>Fracture right hip accident</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>At 8:00 a.m. on 10-17-60 patient was found in bed with a comminuted, intertrochanteric fracture of right hip.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>At 8:00 a.m. on 10-17-60 patient was found in bed with a comminuted, intertrochanteric fracture of right hip.</b>			
20c. TIME OF INJURY Month, Day, Year <b>8:00 p.m. 10-17 19 60</b>				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>			
20e. (City or town) <b>Catonsville 28, Maryland</b>				20f. (State) <b>Maryland</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>George M. Kieffer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov 15, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Washington D. C.</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gracis Soni</b>				ADDRESS <b>4739 Balt. Ave Hyattsville</b>		24a. REC'D BY REGISTRAR <b>NOV 16 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



## CERTIFICATE OF DEATH

Reg. Dist. No.

12260

12294

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Merrymount</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Merrymount</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8413 Merrymount Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alexander</b> Middle <b>C.</b> Last <b>Guest</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1896</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sunpaper</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Guest</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Steiner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1</b>	
17. INFORMANT <b>Mrs. Johanna E. Guest-8413 Merrymount Dr.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C.V.A.</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastatic carcinoma of bowel.</b> DUE TO (c) <b>Embolus, left leg.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Embolus, left leg.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/11</b> , 19 <b>60</b> , to <b>11/13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11/11</b> , 19 <b>60</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. J. Elin</b>		ADDRESS (Street, city or town, state) <b>8627 Liberty Rd. Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Morton Elin</b>		DATE SIGNED <b>11/16/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Arma cost</b>		24a. REC'D BY REGISTRAR <b>NOV 16 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>		24c. ADDRESS <b>Ellsworth Arma cost-4600 Liberty Heights Ave.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12900

OFFICE OF DEATH

12900

John E. O'Connell, 12900, Baltimore, Maryland, USA

John E. O'Connell, 12900, Baltimore, Maryland, USA

John E. O'Connell, 12900, Baltimore, Maryland, USA

John E. O'Connell, 12900, Baltimore, Maryland, USA

John E. O'Connell, 12900, Baltimore, Maryland, USA

John E. O'Connell, 12900, Baltimore, Maryland, USA

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John E. O'Connell, 12900, Baltimore, Maryland, USA

John E. O'Connell, 12900, Baltimore, Maryland, USA

John E. O'Connell, 12900, Baltimore, Maryland, USA

John E. O'Connell, 12900, Baltimore, Maryland, USA

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE -</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort. Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>in</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>North Point Rd</b>		d. STREET ADDRESS <b># 1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>HAGER</b> Last		4. DATE OF DEATH Month <b>Nov</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sep. 14. 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore - Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Nicholas Hager</b>		14. MOTHER'S MAIDEN NAME <b>Mary (last unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>2-7-01-5144</b>	
17. INFORMANT <b>(deceased)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic and</b> DUE TO <b>Hypertensive C. V. disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 yrs</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1945</b> , to <b>Nov 6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Nov. 6</b> , 19 <b>60</b> , and that death occurred at <b>11:25</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louis N. Tollin</b> M.D.		ADDRESS (Street, city or town, state) <b>6908 N. POINT Rd.</b> DATE SIGNED <b>11/6/60</b>	
PHYSICIAN'S NAME (Type) <b>LOUIS N. TOLLIN</b>		<b>BALTIMORE - 19 - MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/9/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>OUR OWN</b>		22d. LOCATION (City, town, or county) (State) <b>COUGATE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ULLRICH FUNERAL HOME DUNDALK MD</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>NOV 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1950

CERTIFICATE OF DEATH

Page No. 10

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
JACK IN U.S.A.		M		W		1910		New York		1950		New York		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Date of filing		20. Registrar's signature		21. Registrar's title		22. Registrar's office		23. Registrar's phone		24. Registrar's fax	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED  
BUREAU OF VITAL STATISTICS  
U.S. DEPARTMENT OF HEALTH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12296

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12262

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oliver Beach (20)</b>		c. LENGTH OF STAY IN 1b <b>(20)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 231 Rt. 14</b>		d. STREET ADDRESS <b>Box 231 Rt. 14</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ARTHUR W. HALES</b>		4. DATE OF DEATH <b>Nov. 7, 1960</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 5, 1905</b>	
9. AGE (In years lost birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Storekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E. Hales</b>		14. MOTHER'S MAIDEN NAME <b>Ida Armstrong</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577 09 0153</b>	
17. INFORMANT <b>Audra Hales</b> Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF BILIARY DUCTS WITH METASTASES</b> DUE TO <b>155.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUCTS WITH METASTASES</b> (c) <b>6 MO</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 13, 1960</b> to <b>NOV. 7, 1960</b> that (I) (we) last saw the deceased alive on <b>NOV. 1, 1960</b> , and that death occurred at <b>12:35 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Miceli</b> M.D.		22b. DATE SIGNED <b>11/8/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH MICELI, M.D.</b>		22d. ADDRESS <b>108 S. TAYLOR AVE BALTO. 21 M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>11/8/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gays Funeral Home</b>		23d. LOCATION (City, town, or county) (State) <b>Rocky Mt. Edgecombe Co., N.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Bruzdinski</b> ADDRESS <b>1407 Eastern Ave #21</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 10 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

1898

CERTIFICATE OF DEATH

1898



OHIO

WILLIAM

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12297

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Allen</u> Last <u>Ham</u>		4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/21/11</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>49</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Phila. PA.</u>	
13. FATHER'S NAME <u>Richard M. Ham.</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Rowe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WWII</u>		17. INFORMANT <u>Wife</u> Address <u>Haskell S. Ham, Falls Church, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STRANGULATION</u> DUE TO <u>Self-Imposed Hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>974X</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Heavy Suf in Essay Probly Sta. Cell</u>	
20c. TIME OF INJURY Month, Day, Year <u>Nov 11/22 1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Prison</u>	20f. (City or town) <u>Essex</u> (County) <u>Baltimore</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BIRTH INFORMATION, 22b. DATE THEREOF <u>11/29/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>		22d. LOCATION (City, town, or county) <u>Arlington</u> (State) <u>VA</u>	
ADDRESS <u>Riverdale, Md</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12298

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>3 V01-4</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3334 Willoughby Road</i>		d. STREET ADDRESS <i>5500 Fernpark Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Nellie</i> First Middle Last		4. DATE OF DEATH Month <i>Nov.</i> Day <i>27th</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 17, 1890</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Stemler</i>	
14. MOTHER'S MAIDEN NAME <i>Emma Michael</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>213-20-9577</i>		17. INFORMANT Address <i>Mr. Elmer Hanssen, 5500 Fernpark Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Hemorrhage</i> 333X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerotic Vasc. Disease</i> DUE TO (c) <i>Age</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3-4 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <i>Repeated Cereb. Hemorrhages &amp; Amyloid</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>11/24/60</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/24/60</i> , 19 <i>60</i> , to <i>11/27/60</i> , that I last saw the deceased alive on <i>11/25/60</i> , 19 <i>60</i> , and that death occurred at <i>2:00 AM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank T. Kasik</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>9005 Harford Rd, Balto 14 Md, 11/28/60</i>	
PHYSICIAN'S NAME (Type) <i>FRANK T KASIK</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/30/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 29 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ORIGINAL FILED

15232

CERTIFICATE OF DEATH

15232

NAME	John Doe
AGE	45
SEX	Male
RACE	White
DATE OF BIRTH	10/10/1910
DATE OF DEATH	11/15/1955
PLACE OF BIRTH	New York, N.Y.
PLACE OF DEATH	New York, N.Y.
Cause of Death	Heart Disease
Signature	[Signature]
Witness	[Signature]
Registrar	[Signature]



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12265

12299

Items 5, 13 Film 2274 11-16-60 et

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Catons Ridge, Catonsville</u>		d. STREET ADDRESS <u>6616 Fairmount Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Sherwood</u> Middle <u>Harbaugh</u> Last		4. DATE OF DEATH <u>November 10, 1960</u> Month <u>10</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1893</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Boring</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Bauer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Robert Harbaugh, 6616 Fairmount Ave.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary failure</u> <u>4444X</u> DUE TO (b) <u>High Blood pressure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 24, 1960</u> to <u>11/10, 1960</u> that (I) (we) lost the deceased olive on <u>11/9/1960</u> , and that death occurred on <u>11/10/1960</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Cliff Ratliff, Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/11/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		22d. ADDRESS <u>4605 EDMONDSON AVE #29</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 12, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank D. Newell, Pikesville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 14 '60</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1998

CERTIFICATE OF DEATH

1998



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12211

CERTIFICATE OF DEATH

12266

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (arbutus)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Baltimore (Arbutus)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1274 Maple Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eugene F.</b> Middle <b>Hargadon</b> Last		4. DATE OF DEATH Month <b>Nov.</b> Day <b>6,</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 8, 1895</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baltimore Federal Savings &amp; Loan</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Bryan C. Hargadon</b>		14. MOTHER'S MAIDEN NAME <b>Helen M. Born</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-24-6044</b>	
17. INFORMANT (wife) <b>Anna M. Hargadon</b>		Address <b>1274 Maple Ave. #27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the lungs (metastases)</b> DUE TO (b) <b>Myocardial disease, st. post infarctum</b> DUE TO (c) <b>generalized arteriosclerosis, hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>months</b> <b>years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 24, 1960</b> to <b>Nov. 6, 1960</b> that (I) (we) last saw the deceased alive on <b>Nov. 6, 1960</b> and that death occurred at <b>11 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry Armanas</b>		22b. DATE SIGNED <b>Nov. 7, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry Armanas, M.D.</b>		22d. ADDRESS <b>1934 Wilkens Avenue</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR <b>NOV 9 '60</b>	
ADDRESS <b>4107 Wilkens Avenue</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

BP

1936

CERTIFICATE OF DEATH

1936

Baltimore

Baltimore

Baltimore (Address)

Baltimore (Address)

1275 Maple Avenue

1275 Maple Avenue

Nov. 1, 1936

Nov. 1, 1936

Male

Baltimore Federal Savings & Loan

Baltimore

Edward C. Harrington

Edward C. Harrington

(Wife)

27-28-29th Ave. N. Harrington 1275 Maple Ave. N.

Baltimore (Address)

Baltimore (Address)

Baltimore (Address)



1936

1936

Baltimore (Address)

Baltimore (Address)

Baltimore (Address)

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 9 Film 275 11-28-60 et											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>						c. LENGTH OF STAY IN 1b <b>Baltimore</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS <b>1926 Wilkins Avenue -20</b>					
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>E.</b> Last <b>HARMS</b>						4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>60</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/28/1911</b>		9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARBER</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Richard E. Harms</b>						14. MOTHER'S MAIDEN NAME <b>Lena A. Crist</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-24-1269</b>		17. INFORMANT <b>MR. George Snyder</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stab wounds of abdomen.</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>9822X</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stabbed in abdomen.</b>							
20c. TIME OF INJURY Hour <b>9:30</b> a.m. p.m. <b>11/17/60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) <b>Catonsville</b>		(County) <b>Baltimore</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>November 18, 1960</b>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 21, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or country) <b>BALTO. MD.</b>		(State)			
23. FUNERAL DIRECTOR <b>G. TRYMAN Schwab</b>						ADDRESS <b>3512 Frederick Ave. (29)</b>		24a. REC'D BY REGISTRAR <b>NOV 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with four copies of this certificate. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY		BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		PARKVILLE- (14)		c. LENGTH OF STAY IN 15		a. STATE		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2011 East Joppa Road		55 PARKVILLE- BALTO # TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		EARLE		HARRINGTON		116 WILLOW AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Nov. 24, 1899		60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
STOREKEEPER		FOOD - RETAIL		MARYLAND		USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
WILLIAM HARRINGTON				ELLA THUMBLERT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT					
NO		NONE		MRS. EARLE HARRINGTON, TOWSON, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE, 331X DUE TO SPONTANEOUS Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour e.m. p.m.		19		While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME (Type)				W. Bradley King, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		11/19/60	
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
BURIAL				Nov. 21, 1960		MAY'S CHAPEL CEM.		TIMONION, MD.	
23. FUNERAL DIRECTOR						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
John Burne' Stone, TOWSON, MD.						NOV 22 '60		Arthur S. Kraus	

12268

1985

514

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12269

12302

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>433 S. ROLLING RD.</u>				d. STREET ADDRESS <u>433 S. ROLLING RD.</u>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>HEINMULLER</u> Last <u>HEINMULLER</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/20/83</u>		9. AGE (In years lost birthday) <u>77</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>ADAM HEINMULLER</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. STAHL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>MD</u>		17. INFORMANT <u>Mrs Mary E Heinmuller</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis &amp; Hypertension</u>  DUE TO  (b) _____  DUE TO  (c) _____</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u>lying cause lost.</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Degenerative cardiovascular lesion</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> 19 <u>58</u> to <u>11/9</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11/9</u> 19 <u>60</u> and that death occurred at <u>7P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>James E. Rome</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/12/60</u>		<u>London Park</u>		<u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Donna Mott + Son</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

1880

1880

ST-35  
M.D.  
ST-35  
FATHER  
MOTHER  
BORN  
DIED  
PLACE OF BIRTH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SEX  
AGE  
OCCUPATION  
RELATIONSHIP TO DECEASED  
MARITAL STATUS  
EDUCATION  
RELIGION  
RACE  
COLOR  
HEIGHT  
WEIGHT  
HAIR  
EYES  
SKIN  
TENDRILS  
SCARS  
TATTOOS  
DENTAL  
SPECIAL FEATURES  
REMARKS  
SIGNATURE OF REGISTRAR  
DATE  
PLACE

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH  
1880

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12303

CERTIFICATE OF DEATH

12270

Item 1c Film 275 11-29-60 et

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>P.G</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>15Y 11M 1D</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elaine</u> Middle <u>Bowell</u> Last <u>Heiskell</u>				4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-16-1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Lucien W. Bowell</u>				14. MOTHER'S MAIDEN NAME <u>NAN Fitzhugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Spring Grove State Hospital Records.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterioscl. Cardio Vasc. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, gener., severe</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-8-1960</u> to <u>11-9-1960</u> , that (I) (we) last saw the deceased alive on <u>11-9-1960</u> , and that death occurred at <u>5:20</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar</u> M.D.				22b. DATE SIGNED <u>11/9/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>				22d. ADDRESS <u>Spring Grove State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Nov 12 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Ignace Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Oxon Hill Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>				25a. REC'D BY REGISTRAR <u>300 4 St NE</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	
DATE <u>NOV 14 '60</u>							

15301

CERTIFICATE OF DEATH

15301

Blank certificate form with horizontal lines for text entry. The form includes fields for patient information, date of death, cause of death, and a signature line at the bottom. There are two punch holes on the right side of the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
12304  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12271

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex 21</b>	
3. NAME OF DECEASED (Type or print) First <b>ETHLEN</b> Middle <b>ALETHA</b> Last <b>HICKEY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 21, 1876</b>
9. AGE (In years lost birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George B. Sanders</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Crew</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Emily E. Jacob-944 Renfrew Street #21</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 - Anterior - Septic Heart Disease</b> DUE TO (b) <b>Broncho - Pneumonia</b> DUE TO (c) <b>Senile Psychosis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Anterior - Septic</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs 5 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 14</b> 19 <b>54</b> to <b>Nov. 21</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Nov. 20</b> 19 <b>60</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl L. Chambers</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		22d. ADDRESS <b>4108 Liberty Hts. Balto - 7 - Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/23/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tickins, Inc., Balto</b>		25a. REC'D BY REGISTRAR <b>NOV 28 60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Fennell</b>		DATE	

18331

CERTIFICATE OF DEATH

18304

State of Maryland  
County of Baltimore  
City of Baltimore  
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 10th day of May, 1901, at the City of Baltimore, Maryland, died George R. [Name], a male, of the age of 40 years, of the disease of Myocarditis, the result of acute inflammation of the heart muscle, and that he had been afflicted with the same for several days prior to his death.

Witness my hand and the seal of my office this 10th day of May, 1901.  
[Signature]  
[Seal]  
I, the undersigned, a duly qualified and licensed physician, do hereby certify that the above is a true and correct copy of the original certificate of death filed in my office on the 10th day of May, 1901.  
[Signature]  
[Seal]  
Filed for record this 10th day of May, 1901.  
[Signature]  
[Seal]

12305

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Co.</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3826 Patterson Ave.</b>				d. STREET ADDRESS <b>3826 Patterson Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>CORNELIA</b>		Middle <b>HOUSTON</b>		Last <b>HILL</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 27, 1885</b>	
9. AGE (In years lost birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Triadelphia, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Thomas F. Lansdale</b>				14. MOTHER'S MAIDEN NAME <b>Eliza W. Strain</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>Janet Himes-3826 Patterson Ave.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY - THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO (c) <b>5 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug. 12</b> , 19 <b>40</b> , to <b>Nov. 14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Nov. 14</b> , 19 <b>60</b> , and that death occurred at <b>10:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>11-16-60</b> DATE SIGNED ACTUAL SIGNATURE <b>Earl L. Chambers</b> M.D. <b>4108 LIBERTY - HEIGHTS - AVE</b> PHYSICIAN'S NAME (Type) <b>EARL L. CHAMBERS M.D. 13 BALTIMORE - MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/17/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>All Hallows Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Davidsonville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>				24a. REC'D BY REGISTRAR <b>NOV 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1952

CENTRIC OF LEAD

1952

Baltimore

Maryland

White

Baltimore

Baltimore Co.

Baltimore Co.

300 Lexington Ave.

300 Lexington Ave.

November 14, 1952

ROBERTSON, ELLA

CORNELIA

73

July 27, 1952

EX

White

Female

Philadelphia, Maryland, USA

At home

Ellis W. Strain

Thomas F. Lashelle

Janet James-1840 Patterson Ave.

None

No

Continuity - Confidential

WOMANLY & WARM GROOMING

3 days

1 day

Maryland

DAVIDSON, LEO

All Rights Reserved

11/17/52

2nd

Ellsworth Armsport-1000 Liberty Bell Ave.

Continuity - Confidential

12300

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Inverness</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Inverness</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>400 Bay Side Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Michael A Hill</u>				4. DATE OF DEATH Month Day Year <u>November 12 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2 1881</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Mln.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beth steel ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Rittner Hill</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Stiles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Herman Schultz 54 Broadship Dundalk Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>H-S-C-V-Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M B Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Melvin B Davis 6800 Morningson Rd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11/13/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Howard County</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12274

12307

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>10 mth3dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>Gotwald</b> Last <b>Holahan</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 26, 1914</b>
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Eng. Lit.</b>	11. BIRTHPLACE (State or foreign country) <b>Penna.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	
16. SOCIAL SECURITY NO. <b>1942-46</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 18</b> , 19 <b>60</b> , to <b>Nov. 21</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Nov. 21</b> , 19 <b>60</b> , and that death occurred at <b>2:15 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachler</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>11-21-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-23-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town or county) (State) <b>Prince George's Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Julius M. Saylor</b>		24a. REC'D BY REGISTRAR <b>Nov 28 60</b>	
ADDRESS <b>Annapolis Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12105

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
OCCUPATION		EDUCATION	
MARITAL STATUS		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12308

CERTIFICATE OF DEATH

12275

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STOKESVILLE Uniontown</b>		d. STREET ADDRESS <b>c/o Miss E. Cookson</b> <b>PULLEN NURSING HOME</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILBUR</b> Middle <b>M.</b> Last <b>HULL</b>		4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 6, 1894</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN -Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARRY C. HULL</b>		14. MOTHER'S MAIDEN NAME <b>FANNIE C. MYERS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO. <b>470-18-3018</b>	
17. INFORMANT <b>CLIN REC VAH BALTO 18 MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> <b>586X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>OBSTRUCTIVE JAUNDICE</b> DUE TO (c) <b>UNKNOWN</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tuberculosis, inactive, of lungs, spine, cervical glands, rt. kidney (Surgically)</b> Removed 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>002X</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>11/10/60</b> to <b>11/14/1960</b> , that (X) (we) last saw the deceased alive on <b>Nov. 14</b> 19 <b>60</b> , and that death occurred at <b>4:00 PM</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Frederick S. Donaldson</b>		22b. DATE <b>11/15/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/17/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pipe Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Myers, Jr., Westminster, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 18 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>			

1887

CENTRAL OFFICE OF HEALTH

1887

CERTIFICATE

CERTIFICATE

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film 6275 11-29-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12276

12309

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>5 Y 8M 9D</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				e. STREET ADDRESS <u>1302 Appleby Ave.</u>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>LYDIA</u> Last <u>THURLEY</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-16-80</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>ABRAHAM KROUT</u>				14. MOTHER'S MAIDEN NAME <u>ELLIE W. (KROUT) Waltemyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>C</u>			
17. INFORMANT Address <u>L. WEST BROOK (PHONE: Spring Point 2649)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>MARCH 3</u> , 19 <u>55</u> , to <u>NOV. 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>NOV. 12</u> , 19 <u>60</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Loretta Y. F. Hsu</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> PHYSICIAN'S NAME (Type) <u>LORETTA Y. F. HSU</u> <u>CATONSVILLE 28, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 15, 1960</u>		<u>Mt. Zion Cemetery</u>		<u>Freeland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Jacob Hartenstein New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>NOV 15 '60</u>		<u>Arthur L. Kraus</u>	







TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12310

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12277

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>		d. STREET ADDRESS <u>526 Chateau Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6229 N. Charles Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. Angelo Vincent Ingui</u>				4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec, 24, 1918</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Security</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Ingui, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Gaetana De Bole</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 2 216-14-4735</u>		17. INFORMANT <u>Mr. Joseph Ingui, Jr. 3406 Belair Road.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>272X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes Insipidus</u> (c) <u>1 yr.</u> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/1/60</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>Baltimore, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>Leonard J. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

## 0.0521

# CERTIFICATE OF DEATH

12311

Items 12 & 23d. Film G274 11/17/60 iwl

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VR A1S (4)  
15M 9/59

1937

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1937

May 11 1937

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12312

12279

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>20 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>2422 WILKINS AVENUE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>G.</b> Last <b>JACOBS</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 1, 1900</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mailer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sun Papers</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ANDREW JACOBS</b>		14. MOTHER'S MAIDEN NAME <b>BERTHA WORLEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>705-12-3467</b>	
17. INFORMANT <b>Clin. Records, VA Hospt. Balb. Md. Ft. Howard Div.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>THROMBOPHLEBITIS LEFT LEG</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>1 MONTH</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS OBLITERANS. 2. OBSTRUCTIVE EMPHYSEMA.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>October 23, 1960</b> to <b>November 12, 1960</b> , that (I) (we) last saw the deceased alive on <b>November 12, 1960</b> , and that death occurred at <b>11:45 PM</b> on the causes and on the date stated above.			
22a. SIGNATURE <i>Walter J. Pijanowski</i>		22b. DATE SIGNED <b>11/13/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. MD. DET. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-16-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>George L. Schwab</i>		25a. REC'D BY REGISTRAR <b>NOV 15 '60</b>	
25b. REGISTRAR'S SIGNATURE <i>Christina S. Hanna</i>			

GEORGE L. SCHWAB FUNERAL HOME 2101 Frederick Ave.

Baltimore 23, Maryland

CERTIFICATE OF DEATH

IN LAST

DATE

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

CHIEF OF POLICE

DECEASED

DECEASED



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glen Falls Road</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>MICHELLE MONIQUE JOHNSON</b>					4. DATE OF DEATH Month Day Year <b>Nov. 26 19 60</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 3, 1960</b>		9. AGE (In years last birthday) yrs. Months Days <b>3 23</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland (Belle City)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herbert Bernard Johnson</b>					14. MOTHER'S MAIDEN NAME <b>Lilly Mae Williams</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Herbert B. Johnson, Reisterstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pylorus spasm since birth.</b>									INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>none</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>none</b>		20g. (County) <b>none</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <b>D.D. Caples</b> M.D. EXAMINER'S NAME (Type) <b>D. D. CAPLES, M. D., 6 Hanover Rd., Reisterstown, Md.</b> DATE SIGNED <b>11-26-60</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Petty Grove</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore Co. Md.</b>			
23. FUNERAL DIRECTOR Address <b>Adelington S. Phillips 1808 N. Monmouth</b>					24a. REC'D BY REGISTRAR <b>DEC 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

12280

FOR WIFE  
DANIEL B. BRYAN

1

Religious

Religious

Religious

MIDDLE

Colored

None

Herbert Bernard Johnson

no

Thompson

None

None

None

None

None

John's name also given

U. S. MARSH, ... & Harvey W. Johnson, Md.

11-20-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
12313  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12281

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b> c. LENGTH OF STAY IN lb <b>36 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b> d. STREET ADDRESS <b>RFD #2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>FRANKLIN</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1939</b>
9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR Months <b>21</b> Days <b>19</b> Hours <b>60</b> Min.	IF UNDER 24 HRS. Hours <b>60</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	11. BIRTHPLACE (State or foreign country) <b>Easton, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Walter Jones</b>	
14. MOTHER'S MAIDEN NAME <b>Ida Richardson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>219-36-6197</b>		17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT MELANOMA, SKIN OF ANTERIOR CHEST WALL</b> <b>190.5</b> <b>XXXX WITH METASTASIS TO THE BRAIN AND LUNGS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>EDEMA OF THE LUNGS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 YEARS</b> <b>1 DAY</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>September 28, 1960</b> , to <b>November 3, 1960</b> , that (H) (we) last saw the deceased alive on <b>Nov. 3, 1960</b> , and that death occurred at <b>1:15</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Frederick S. Donaldson</b> 22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>		22b. DATE SIGNED <b>11/7/60</b> 22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/7/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bozman Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Bozman, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. H. Amberton Harrison</b> ADDRESS <b>L. H. Amberton Harrison</b>		25a. REG'D BY REGISTRAR <b>NOV 9 1960</b> DATE <b>md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

CERTIFICATE OF DEATH

12713

12713

NAME OF DECEASED

AGE

SEX

DATE

TIME

PLACE

CAUSE

MANNER

DATE

TIME

PLACE

U. S. NAVY

U. S. NAVY

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U. S. NAVY

12314

CERTIFICATE OF DEATH

Reg. Dist. No. 12282

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Balt.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville 52</i>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <i>House of The Pines - Nursing Home</i>		d. STREET ADDRESS <i>3700 Belston Drive 29</i>	
3. NAME OF DECEASED (Type or print) <i>CAROLINE</i> First <i>KALTER</i> Middle Last		4. DATE OF DEATH <i>Nov. 21 1960</i> Month Day Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 19 1887</i> 9. AGE (In years last birthday) <i>73</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Pliss</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Henry E. Kalter</i> Address <i>1158 St. Agnes Lane 7</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Drugs / Numbness</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <i>7-30-60</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>7-30-60</i> 19 <i>11-21-60</i> 19 <i>60</i> , that I last saw the deceased alive on <i>11-20-60</i> 19 <i>60</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Harry S. Gimbel</i> M.D. <i>4605 Edmondson Ave</i>		ADDRESS (Street, city or town, state) <i>Balt City Md</i> DATE SIGNED <i>11-22-60</i>	
PHYSICIAN'S NAME (Type) <i>HARRY S. GIMBEL</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Nov 25/60</i>	
22b. DATE THEREOF <i>Nov 25/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Western</i>	
22d. LOCATION (City, town, or county) (State) <i>Balt City Md</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Burke</i> ADDRESS <i>5311 Edmondson Ave</i>	
24a. REC'D BY REGISTRAR DATE <i>Nov 28 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

12814

Page One of Two

1. Name of Deceased <i>John A. Smith</i>		2. Sex <i>Male</i>		3. Date of Birth <i>10/15/1925</i>		4. Place of Birth <i>Honolulu, Hawaii</i>	
5. Date of Death <i>11/10/1985</i>		6. Time of Death <i>10:30 AM</i>		7. Place of Death <i>Honolulu, Hawaii</i>		8. Cause of Death <i>Heart Disease</i>	
9. Immediate Cause of Death <i>Myocardial Infarction</i>		10. Underlying Cause of Death <i>Coronary Artery Disease</i>		11. Manner of Death <i>Natural</i>		12. Signature of Physician <i>Dr. J. K. Smith</i>	
13. Signature of Registrar <i>John A. Smith</i>		14. Signature of Deceased <i>John A. Smith</i>		15. Signature of Next of Kin <i>John A. Smith</i>		16. Signature of Burial Director <i>John A. Smith</i>	
17. Signature of Medical Examiner <i>John A. Smith</i>		18. Signature of Coroner <i>John A. Smith</i>		19. Signature of District Attorney <i>John A. Smith</i>		20. Signature of County Clerk <i>John A. Smith</i>	
21. Signature of State Health Officer <i>John A. Smith</i>		22. Signature of State Surgeon General <i>John A. Smith</i>		23. Signature of State Department of Health <i>John A. Smith</i>		24. Signature of State Department of Health <i>John A. Smith</i>	
25. Signature of State Department of Health <i>John A. Smith</i>		26. Signature of State Department of Health <i>John A. Smith</i>		27. Signature of State Department of Health <i>John A. Smith</i>		28. Signature of State Department of Health <i>John A. Smith</i>	
29. Signature of State Department of Health <i>John A. Smith</i>		30. Signature of State Department of Health <i>John A. Smith</i>		31. Signature of State Department of Health <i>John A. Smith</i>		32. Signature of State Department of Health <i>John A. Smith</i>	
33. Signature of State Department of Health <i>John A. Smith</i>		34. Signature of State Department of Health <i>John A. Smith</i>		35. Signature of State Department of Health <i>John A. Smith</i>		36. Signature of State Department of Health <i>John A. Smith</i>	
37. Signature of State Department of Health <i>John A. Smith</i>		38. Signature of State Department of Health <i>John A. Smith</i>		39. Signature of State Department of Health <i>John A. Smith</i>		40. Signature of State Department of Health <i>John A. Smith</i>	
41. Signature of State Department of Health <i>John A. Smith</i>		42. Signature of State Department of Health <i>John A. Smith</i>		43. Signature of State Department of Health <i>John A. Smith</i>		44. Signature of State Department of Health <i>John A. Smith</i>	
45. Signature of State Department of Health <i>John A. Smith</i>		46. Signature of State Department of Health <i>John A. Smith</i>		47. Signature of State Department of Health <i>John A. Smith</i>		48. Signature of State Department of Health <i>John A. Smith</i>	
49. Signature of State Department of Health <i>John A. Smith</i>		50. Signature of State Department of Health <i>John A. Smith</i>		51. Signature of State Department of Health <i>John A. Smith</i>		52. Signature of State Department of Health <i>John A. Smith</i>	
53. Signature of State Department of Health <i>John A. Smith</i>		54. Signature of State Department of Health <i>John A. Smith</i>		55. Signature of State Department of Health <i>John A. Smith</i>		56. Signature of State Department of Health <i>John A. Smith</i>	
57. Signature of State Department of Health <i>John A. Smith</i>		58. Signature of State Department of Health <i>John A. Smith</i>		59. Signature of State Department of Health <i>John A. Smith</i>		60. Signature of State Department of Health <i>John A. Smith</i>	
61. Signature of State Department of Health <i>John A. Smith</i>		62. Signature of State Department of Health <i>John A. Smith</i>		63. Signature of State Department of Health <i>John A. Smith</i>		64. Signature of State Department of Health <i>John A. Smith</i>	
65. Signature of State Department of Health <i>John A. Smith</i>		66. Signature of State Department of Health <i>John A. Smith</i>		67. Signature of State Department of Health <i>John A. Smith</i>		68. Signature of State Department of Health <i>John A. Smith</i>	
69. Signature of State Department of Health <i>John A. Smith</i>		70. Signature of State Department of Health <i>John A. Smith</i>		71. Signature of State Department of Health <i>John A. Smith</i>		72. Signature of State Department of Health <i>John A. Smith</i>	
73. Signature of State Department of Health <i>John A. Smith</i>		74. Signature of State Department of Health <i>John A. Smith</i>		75. Signature of State Department of Health <i>John A. Smith</i>		76. Signature of State Department of Health <i>John A. Smith</i>	
77. Signature of State Department of Health <i>John A. Smith</i>		78. Signature of State Department of Health <i>John A. Smith</i>		79. Signature of State Department of Health <i>John A. Smith</i>		80. Signature of State Department of Health <i>John A. Smith</i>	
81. Signature of State Department of Health <i>John A. Smith</i>		82. Signature of State Department of Health <i>John A. Smith</i>		83. Signature of State Department of Health <i>John A. Smith</i>		84. Signature of State Department of Health <i>John A. Smith</i>	
85. Signature of State Department of Health <i>John A. Smith</i>		86. Signature of State Department of Health <i>John A. Smith</i>		87. Signature of State Department of Health <i>John A. Smith</i>		88. Signature of State Department of Health <i>John A. Smith</i>	
89. Signature of State Department of Health <i>John A. Smith</i>		90. Signature of State Department of Health <i>John A. Smith</i>		91. Signature of State Department of Health <i>John A. Smith</i>		92. Signature of State Department of Health <i>John A. Smith</i>	
93. Signature of State Department of Health <i>John A. Smith</i>		94. Signature of State Department of Health <i>John A. Smith</i>		95. Signature of State Department of Health <i>John A. Smith</i>		96. Signature of State Department of Health <i>John A. Smith</i>	
97. Signature of State Department of Health <i>John A. Smith</i>		98. Signature of State Department of Health <i>John A. Smith</i>		99. Signature of State Department of Health <i>John A. Smith</i>		100. Signature of State Department of Health <i>John A. Smith</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

12315

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12283

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester County</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>				c. LENGTH OF STAY IN 1b <b>73 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taylors Island</b>			
f. STREET ADDRESS <b>Box # 112</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IRVING</b> Middle <b>W.</b> Last <b>KANE</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 11, 1896</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min.		IF UNDER 24 HRS. Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Saw Mill</b>			
11. BIRTHPLACE (State or foreign country) <b>Madison, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles W. Kane</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Lee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-1</b>				16. SOCIAL SECURITY NO. <b>219-14-4321</b>			
17. INFORMANT <b>Clinical Records, FORT HOWARD DIVISION</b>				Address <b>VAH Balto.Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA, RIGHT KIDNEY, WITH METASTASES TO</b> RIGHT LUNG Conditions, if any, which gave rise to immediate cause (b), stating the <u>under</u> lying cause lost. XX <b>RIGHT LUNG</b> DUE TO (c) <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 29</b> 19 <b>60</b> to <b>Nov. 10</b> 19 <b>60</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 10</b> 19 <b>60</b> , and that death occurred at <b>A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>NORMAN P. JONES, M.D.</b>				22b. DATE SIGNED <b>11/10/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>NORMAN P. JONES, M.D.</b>				22d. ADDRESS <b>VAH, Fort Howard, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-12-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lanes M.E. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Dorchester County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HERBERT M. ST. CLAIR</b>				25a. REC'D BY REGISTRAR <b>NOV 15 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kane</b>							

050

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2

1

BP



12316

**DO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**THE FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
12317  
CERTIFICATE OF DEATH  
12285

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>d 3 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2216 Cambridge Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM R. KOSERSKE</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>1</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/27/95</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Standard Oil Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Karl Koserske</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Raisner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>215-05-8751</b>	
17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Fort Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>151X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6-12 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Oct. 29 1960</b> to <b>November 1, 1960</b> , that (we) last saw the deceased alive on <b>Nov. 1 19 60</b> , and that death occurred at <b>4:40 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur T. Faulk, M.D.</b>		22b. DATE SIGNED <b>11/1/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arthur T. Faulk, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. MD. FORT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-4-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly Zeiller, Eastern Ave. &amp; Wolfe St. Balto. Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 2 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hauer</b>			

24951



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12318 12286											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>45 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1674 Burnwood Road (12)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>HUGH EDWARD LAW</b>						4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 20, 1890</b>		9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police Officer</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>City Police</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		
13. FATHER'S NAME <b>Edward Law</b>						12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>						16. SOCIAL SECURITY NO. <b>WW I</b>					
17. INFORMANT <b>CLINICAL RECORDS, VAH, Baltimore 18, Maryland</b>						17. INFORMANT <b>CLINICAL RECORDS, VAH, Baltimore 18, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub-thoracic Fracture - Left.</b> 904.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Dilatation of Heart - Chronic Atherosclerosis - Myocardial Infarction.</b> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in bedroom of Home</b> 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9-29-60</b> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Belaire Nursing Home Balto.</b> 20f. (City or town) (County) (State) <b>Balto. Md.</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>JACK O. Collins</b> M.D. EXAMINER'S NAME (Type) <b>JACK O. Collins</b> M.D. Address (Street, city, town, or county) <b>11/16/60</b> (State) <b>Maryland</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-19-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery Baltimore</b>				22d. LOCATION (City, town, or country) <b>Maryland</b>			
23. FUNERAL DIRECTOR <b>Leonard J. Ruck</b>						24a. REC'D BY REGISTRAR <b>NOV 18 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>					



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12319

12287

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>131 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>C.</b> Last <b>LEACH</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 30, 1907</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.		IF UNDER 24 HRS. Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FURNITURE STORE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CHARLES A. LEACH</b>				14. MOTHER'S MAIDEN NAME <b>MARY A. TIMMERMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW-31</b>				16. SOCIAL SECURITY NO. <b>217-03-0547</b>			
17. INFORMANT <b>CLIN REC VAH BALTO 18 MD-FT HOWARD DIVISION</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF THE COLON</b> DUE TO (c) <b>153.8</b>						INTERVAL BETWEEN ONSET AND DEATH <b>18 MONTHS</b> <b>4 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 2, 1960</b> to <b>November 10, 1960</b> that (he) (we) last saw the deceased alive on <b>November 10, 1960</b> , and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>L. B. Smith</i>				22b. DATE SIGNED <b>11-11-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. B. SMITH</b>				22d. ADDRESS <b>M.D. VAH BALTO 18 MD - FT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY W. MEARS &amp; SON</b>				25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

DP

12581

CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

RACE

RELIGION

CAUSE OF DEATH

PLACE OF BIRTH

II-11

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

II-11

DATE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

## CERTIFICATE OF DEATH

12288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>301-4</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Professional House</b>		d. STREET ADDRESS <b>717 Lake Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>-</b> Last <b>Lebovitz</b>		4. DATE OF DEATH Month <b>11-</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-30-1898</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR: Months <b>02</b> Days <b>02</b> Hours <b>02</b> Min. <b>02</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Md</b>	11. BIRTHPLACE (State or foreign country) <b>USA</b>
13. FATHER'S NAME <b>Benjamin</b>		12. MOTHER'S MAIDEN NAME <b>Hannah</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Herman Cohen - 7301 Park Hgts Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastasis Cardiac failure</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Uterus, Carcinomatosis</b> (c) <b>Carcinoma of Uterus, Carcinomatosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July - 1960</b> to <b>Nov 28 - 1960</b> that I last saw the deceased alive on <b>Nov 28</b> , 19 <b>60</b> , and that death occurred at <b>12:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agnes Ullman</b>		ADDRESS (Street, city or town, state) <b>1712 Eutan Place, Baltimore, Md</b>	
PHYSICIAN'S NAME (Type) <b>Agnes Ullman</b>		DATE SIGNED <b>1712 Eutan Place, Baltimore, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-30-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale</b>	22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Rivers</b>		ADDRESS <b>2100 Eutan Place</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

NOV 30 '60

Arthur L. Kraus

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



12321

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN</b>		c. LENGTH OF STAY IN 1b <b>3 MonTHS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1456 CLAIRIDGE ROAD</b>		e. STREET ADDRESS <b>1456 CLAIRIDGE ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>ELLA C. LEE</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>14,</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 13, 1902</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>EDWARD F. KELLEY</b>		14. MOTHER'S MAIDEN NAME <b>MARY E. TIGHE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-18-4059</b>	
17. INFORMANT <b>MR. SAMUEL J. LEE</b>		17. ADDRESS <b>1456 CLAIRIDGE ROAD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Breasts (Bilateral)</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>18 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 1950</b> to <b>11/14, 1960</b> , that I last saw the deceased alive on <b>11/13, 1960</b> , and that death occurred at <b>12:10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thos E Roach</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>3629 Edmondson Ave 11/15/60</b>	
PHYSICIAN'S NAME (Type) <b>Thos E Roach</b>		<b>Ba2to-29-Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/18/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC.</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 17 '60</b>	
<b>BALTIMORE 13, MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12322

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12290

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>5yr3mth12dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1020 Light Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Lewis</b> Last <b>Lewis</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>19,</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1868</b>
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records : SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Heart Disease.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 26</b> 19 <b>56</b> to <b>Nov. 19</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Nov. 19, 1960</b> , and that death occurred <b>6:50 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>H. I. Cholmondeley</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>H. I. Cholmondeley, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		23b. DATE THEREOF <b>11/23/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Haven</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>McLary - 130 E. Fort Lee</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 23 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

13234

NEW HAMP. STATE DEPARTMENT OF HEALTH  
OFFICE OF THE REGISTRAR OF DEATHS  
CERTIFICATE OF DEATH

13234

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12291

12323

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>		c. LENGTH OF STAY IN 1b <b>86 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (6)</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>4203 Valley View Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b>		Middle <b>J.</b>		Last <b>MAHONEY</b>		4. DATE OF DEATH Month <b>November</b>		Day <b>25</b>		Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 28, 1888</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Department Store</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William D. Mahoney</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Cook</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I &amp; II 320-16-8906</b>		17. INFORMANT <b>Clinical Records</b> Address <b>VAH, Baltimore 18, Md. FORT HOWARD DIVISION</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EPIDERMOID CARCINOMA OF LEFT ANTRUM, FAR ADVANCED</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 YEARS</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation: 10/25/57 -Caldwell-Luc Operation, left antrum- Carcinoma, left/</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 31</b> 19 <b>60</b> to <b>November 25</b> 19 <b>60</b> , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>11</b> M., from the causes and on the date stated above.													
22a. SIGNATURE <b>Frederick S. Donaldson</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/25/60</b>					
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>						22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-28-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>				23d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck &amp; Sons, 5305 Harford Rd. Balto.</b>						ADDRESS <b>14, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 30 '60</b>		25b. REGISTRAR'S SIGNATURE <b>James E. Jones</b>			

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial/transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

12292

Reg. Dist. No.....

12324

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Sparks</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparks</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Tanyard Road</u> <u>Sparks</u>				STREET ADDRESS (If rural give location) <u>Tanyard Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Fannie Cole</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 23</u> 19 <u>60</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>1 - 22 - 1872</u>	
9. AGE last birthday <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Cole</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Gorsuch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Robert Pearce Sparks Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443 X IMMEDIATE CAUSE (A) <u>Hypertensive Cardio Vascular Lesions</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19 <u>56</u> , to <u>Nov. 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov. 23</u> , 19 <u>60</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>G. M. France</u>		M. D. <u>Parkston Ind</u>		ADDRESS (Street, city, town, state) <u>11/25/60</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>11-25-60</u>		NAME OF CEMETERY OR CREMATORY <u>Immanuel Epis</u>		LOCATION (City, town, or county) (State) <u>Glencoe Maryland</u>	
24. REC'D BY REGISTRAR <u>NOV 29 '60</u>		REGISTRAR'S SIGNATURE <u>Immanuel Epis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service York Rd</u>		ADDRESS <u>Towson 4</u>	

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# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Date of Death

1. Usual Residence of Deceased

2. Usual Residence of Deceased

3. Usual Residence of Deceased

4. Usual Residence of Deceased

5. Usual Residence of Deceased

6. Usual Residence of Deceased

7. Usual Residence of Deceased

8. Usual Residence of Deceased

9. Usual Residence of Deceased

10. Usual Residence of Deceased

*Robert James*

Frederick Cole

None

11. Medical Examination

12. Medical Examination

13. Medical Examination

14. Medical Examination

15. Medical Examination

16. Medical Examination

17. Medical Examination

18. Medical Examination

19. Medical Examination

20. Medical Examination

21. Medical Examination

22. Medical Examination

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31. Medical Examination

32. Medical Examination

33. Medical Examination

34. Medical Examination

35. Medical Examination

12325

CERTIFICATE OF DEATH

Reg. Dist. No.

12293

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN TB <b>18yr3mth27dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>A.</b> Last <b>Matzen</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 20, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>shipyard</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Matzen</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Giles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac failure and pulmonary edema</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 10, 1960</b> to <b>Nov. 18, 1960</b> , that I last saw the deceased alive on <b>Nov. 18, 1960</b> , and that death occurred at <b>11:35 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>11-18-60</b>			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>NOV-21-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Singleton Funeral Home - Glen Burnie - md.</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 23 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>C. L. S. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

(M)

<div> <div> <div>12326</div> <div>12294</div> </div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>VS. A15ME</div> <div>5M 7/59</div> </div> </div> <div> <div> <div> <div>12326</div> <div>12294</div> </div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>VS. A15ME</div> <div>5M 7/59</div> </div> </div> <div> <div> <div>12326</div> <div>12294</div> </div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>VS. A15ME</div> <div>5M 7/59</div> </div> </div> </div></div>												<div> <div> <div>12326</div> <div>12294</div> </div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>VS. A15ME</div> <div>5M 7/59</div> </div> </div> <div> <div> <div>12326</div> <div>12294</div> </div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>VS. A15ME</div> <div>5M 7/59</div> </div> </div>											
<div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>BALTIMORE</div> <div>MARYLAND</div> </div>						<div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE</div> <div>MARYLAND</div> <div>b. COUNTY</div> <div>Baltimore</div> </div>																	
<div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Towson</div> <div>c. LENGTH OF STAY IN 1b</div> <div>2 weeks</div> </div>						<div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Owings Mills</div> </div>																	
<div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Shephard Pratt Hospital</div> </div>																							
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>First</div> <div>PATRICIA</div> <div>Middle</div> <div>P.</div> <div>Last</div> <div>MAY</div> </div>						<div> <div>4. DATE OF DEATH</div> <div>Month</div> <div>November</div> <div>Day</div> <div>16</div> <div>Year</div> <div>1960</div> </div>																	
<div> <div>5. SEX</div> <div>Female</div> </div>						<div> <div>6. COLOR OR RACE</div> <div>White</div> </div>																	
<div> <div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> </div>						<div> <div>8. DATE OF BIRTH</div> <div>8/1/1925</div> </div>																	
<div> <div>9. AGE (In years last birthday)</div> <div>35 yrs.</div> </div>						<div> <div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div> <div>Hours</div> <div>Min.</div> </div>																	
<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>None</div> </div>						<div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Massachusetts</div> </div>																	
<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>U.S.A.</div> </div>						<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div>																	
<div> <div>13. FATHER'S NAME</div> <div>Joseph Prescott</div> </div>						<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Dorothy A. Allison</div> </div>																	
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)</div> <div>No</div> </div>						<div> <div>16. SOCIAL SECURITY NO.</div> <div>Unknown</div> </div>																	
<div> <div>17. INFORMANT</div> <div>Herbert A. May, Jr.</div> </div>						<div> <div>Address</div> <div>Above</div> </div>																	
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Asphyxia</div> <div>DUE TO</div> <div>974X</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>(b)</div> <div>Hanging by belt</div> <div>DUE TO</div> <div>(c)</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> </div>																							
<div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>																							
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> <div>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>Apparently hanged self in bathroom</div> </div>						<div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>11/16/60</div> <div>Hour a.m.</div> <div>p.m.</div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>Hospital</div> <div>20f. (City or town)</div> <div>Baltimore</div> <div>(County)</div> <div>Md.</div> <div>(State)</div> </div>																	
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</div> <div>Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> <div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></div> <div>DATE SIGNED</div> <div>11/16/60</div> </div>																							
<div> <div>ACTUAL SIGNATURE</div> <div>W. Bradley King, Jr., M.D.</div> </div>						<div> <div>EXAMINER'S NAME (Type)</div> <div>W. Bradley King, Jr., M.D.</div> </div>																	
<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Entombment</div> </div>						<div> <div>22b. DATE THEREOF</div> <div>11/19/1960</div> </div>																	
<div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>Homewood</div> </div>						<div> <div>22d. LOCATION (City, town, or country)</div> <div>Pittsburgh, Pa.</div> </div>																	
<div> <div>23. FUNERAL DIRECTOR</div> <div>H.W. Jenkins &amp; Sons Co., Baltimore 12, Md.</div> </div>						<div> <div>24a. REC'D BY REGISTRAR</div> <div>NOV 22 '60</div> </div>																	
<div> <div>24b. REGISTRAR'S SIGNATURE</div> <div>Arthur L. Kraus</div> </div>						<div> <div>24c. REGISTRAR'S SIGNATURE</div> <div>Arthur L. Kraus</div> </div>																	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12295

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson / Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Presbyterian Home</b>		d. STREET ADDRESS <b>402 W. Saratoga St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Laura K. McDaniel</b>		4. DATE OF DEATH <b>November 1, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 7, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Millener</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Milton McDaniel</b>		14. MOTHER'S MAIDEN NAME <b>Francis E. Elkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>T.E. Elliott</b>		Address <b>Presbyterian Home</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>the deceased</del> ) attended the deceased from <b>January 1958</b> to <b>Nov. 1</b> 19 <b>60</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>October 26</b> 19 <b>60</b> , and that death occurred at <b>12A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>S. J. Venable, Jr. M.D.</b>		22b. DATE SIGNED <b>November 1, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. S.J. Venable, Jr.</b>		22d. ADDRESS <b>7215 York Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 3, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 3 '60</b>	
ADDRESS <b>1900 Eutaw Place</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hance</b>	

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CENTRAL OF NEW YORK

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## CERTIFICATE OF DEATH

Reg. Dist. No.

12328

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural: Towson</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eudowood Sanatorium Towson 4, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO 12,</u>	
		d. STREET ADDRESS <u>1 107. Dunkirk Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>H. MC FEELY</u> Middle <u>MC FEELY</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-1898</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Centerville VS Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>VS</u>	
13. FATHER'S NAME <u>WILLIAM MC FEELY</u>		14. MOTHER'S MAIDEN NAME <u>FRANCIS HARPER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Personal History</u>		Address <u>Hospital Records, Eudowood Sanatorium</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS, ADVANCED</u> DUE TO (b) <u>0 02X</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-25</u> , 19 <u>57</u> to <u>11-4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11-3</u> , 19 <u>60</u> , and that death occurred at <u>4:05 a</u> M, from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <u>Milton B. Kress</u>		ADDRESS (Street, city or town, state) <u>Eudowood Sanatorium</u>	
PHYSICIAN'S NAME (Type) <u>Milton B. Kress, M.D.</u>		Towson 4, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 5 - 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Centerville</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Barton Porter, Pres Centerville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. S. Finner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 22

DATE OF DEATH

NAME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

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12204

## CERTIFICATE OF DEATH

Reg. Dist. No. 12297

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Res., 2914 Dunmurry Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Res., 2914 Dunmurry Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>A. Mc Lyman Sr.</b> Last <b></b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1881</b>
9. AGE (In years last birthday) <b>79 yrs.</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Fuel Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Newport, R.I.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Mc Lyman</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-8280</b>	
17. INFORMANT <b>Mrs. Elizabeth Mc Lyman</b>		Address <b>2914 Dunmurry Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the prostate</b> <b>177X</b> DUE TO <b>with generalized metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-3</b> , 19 <b>60</b> , to <b>11-13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11-13</b> , 19 <b>60</b> , and that death occurred at <b>12 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7001 Mornington Rd</b> DATE SIGNED <b></b>			
ACTUAL SIGNATURE <b>Eugene F Nevy</b>		M.D. <b>Dundalk, Md</b>	
PHYSICIAN'S NAME (Type) <b>Eugene F Nevy</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-16-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Washington Blvd. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



de la Nueva España, en el primer tercio del siglo XVII, en el que se produjo una gran crisis económica y social, que se reflejó en la literatura de la época. En este contexto, el autor de la obra, Juan de Ovando, se plantea la necesidad de una reforma educativa que permita a la juventud de la Nueva España acceder a la cultura y a la ciencia, y así poder contribuir al desarrollo de la colonia. Para ello, propone la creación de una academia que se dedique a la enseñanza de las ciencias y de las artes, y que funcione como un centro de investigación y de difusión de los conocimientos. Esta academia, según el autor, debería estar compuesta por un grupo de profesores y de alumnos, que se dedicarían a estudiar y a enseñar las ciencias y las artes, y que tendrían a su disposición una biblioteca y un laboratorio. Además, el autor propone que la academia funcione como un centro de reunión para los científicos y los artistas, y que se dedique a la realización de experimentos y de obras de arte. En definitiva, el autor de la obra propone una reforma educativa que permita a la juventud de la Nueva España acceder a la cultura y a la ciencia, y así poder contribuir al desarrollo de la colonia.



12329

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6607 Windsor Mill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>VIRGINIA</b> Last <b>MEAD</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1911</b>
9. AGE (In years last birthday) yrs. <b>49</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Stores</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert P. Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Forrester</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-1749</b>	
17. INFORMANT <b>Charles A. Mead-6607 Windsor Mill Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>199-2</b> IMMEDIATE CAUSE (a) <b>Terminal carcinoma with metastasis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <b>5-7 mos.</b>	
21. I certify that I attended the deceased from <b>10/1/60</b> , 19___, to <b>11/3/60</b> , 19___, that I last saw the deceased alive on <b>11/3/60</b> , 19___, and that death occurred at <b>5 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>11/5/60</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>Milton Schlenoff</b>		M.D. <b>11/5/60</b>	
PHYSICIAN'S NAME (Type) <b>Milton Schlenoff, M.D.</b>		<b>6410 Windsor Mill Road - 7</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/8/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ellsworth Armacost-4600 Liberty Hgts. Ave.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		24a. REC'D BY REGISTRAR <b>NOV 7 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 after death. Page 2 of 2 after death. The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 after death. Page 2 of 2 after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1958

CERTIFICATE OF DEATH

1958

Baltimore, Maryland

Female

White

6007 Windsor Mill Road, Baltimore, Maryland

November 25, 1958

May 20, 1911

Baltimore, Maryland

Robert P. Morgan

210-10-1719 Charles A. Mead-6607 Windsor Mill Road

6010 Windsor Mill Road

Baltimore, Maryland

Liberty Light Ave.

TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12299

12330

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>		c. LENGTH OF STAY IN 1b <i>1 1/2 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Paper Mill Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Leopoldine</i> First <i>Michaels</i> Middle <i>Michael</i> Last		4. DATE OF DEATH <i>November 18</i> Month <i>18</i> Day <i>19</i> Year <i>60</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12 May 1878</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Vienna, Austria</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Leo fold Klomun</i>		14. MOTHER'S MAIDEN NAME <i>Theresa Schlesinger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Daughter J. Del Garie</i> Address <i>Phoenix, Ind</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (g).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Melanotic Sarcoma</i> <i>190.9</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 1960</i> to <i>November 1960</i> , that I last saw the deceased alive on <i>18 November 1960</i> , and that death occurred at <i>7:07 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D.		DATE SIGNED <i>Cockeysville 18 Nov 1960</i>	
PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>		<i>Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>11-22-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 22 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

12345

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

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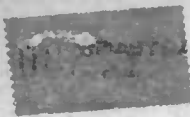
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12331 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5 Towson</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Beaverdam Lodge</b>				d. STREET ADDRESS <b>117 East Susquehanna Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GLENN COLLIER MIEHE</b>				4. DATE OF DEATH <b>November 13, 1960</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 28, 1943</b>		9. AGE (in years last birthday) <b>17 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Towson High School Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Henry W. Miehe</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Collier</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Family Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to submersion while wearing skin diving equipment due to mediastinal and interstitial emphysema due to rapid decompression.</b> 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. TIME OF INJURY Month, Day, Year Hour <b>XX</b> <b>11/13/60</b> p.m.				20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Beaver dam</b>			
20d. (City or town) <b>Cockeysville</b>				20e. (County) <b>Balto.</b>				20f. (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Russell S. Fisher</b>				M.D. <b>Russell S. Fisher, M.D.</b>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>11/14/60</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/17/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Woodlawn Md.</b>			
23a. FUNERAL DIRECTOR <b>John Burns Sons</b>				ADDRESS <b>Towson</b>				24a. REC'D BY REGISTRAR <b>NOV 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12301

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>32 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
f. STREET ADDRESS <b>1109 BATTERY AVENUE</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>C.</b> Last <b>MILLER</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 2, 1925</b>	
9. AGE (In years lost birthday) <b>35</b> yrs.		10. IF UNDER 1 YEAR Months <b>35</b> Days <b>35</b> Hours <b>35</b> Min.		11. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trucker's Helper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>			
13. FATHER'S NAME <b>CECIL MILLER</b>				14. MOTHER'S MAIDEN NAME <b>MILDRED VENNERS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>562-22-8397</b>			
17. INFORMANT <b>CLIN REC VAH BALTIMORE MD-FT HOWARD DIVISION</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RECURRENT TUMOR INVOLVING BRAIN</b> <b>237X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Since 1954</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 5, 1960</b> to <b>November 6, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 6, 1960</b> , and that death occurred at <b>8:15</b> M., from the causes and on the date stated above.							
22a. SIGNATURE <b>Ernest O. Brown</b> M.D.				22b. DATE SIGNED <b>11-6-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Ernest O. Brown</b> M.D.				22d. ADDRESS <b>VAH BALTIMORE 18 MD - FT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>11-9-60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>				23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-BLIGHT INC.</b>				25a. REC'D BY REGISTRAR <b>6009 Harford Road Baltimore 14 Md</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				25c. DATE <b>NOV 9 '60</b>			

1992

Time and a Half

708-352-2277

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12302

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Baltimore</span> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Baltimore</span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Catonsville</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">X Baltimore</span>	
c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">9yr6mth13dys</span>		d. STREET ADDRESS <span style="font-size: 1.2em;">1 4719 Benson Avenue</span>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">SPRING GROVE STATE HOSPITAL</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.2em;">Robert</span> Middle <span style="font-size: 1.2em;">Milliken</span> Last <span style="font-size: 1.2em;">Milliken</span>		<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">11</span> Day <span style="font-size: 1.2em;">17</span> Year <span style="font-size: 1.2em;">1960</span>	
<b>5. SEX</b> <span style="font-size: 1.2em;">male</span>	<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">white</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">February 20, 1899</span>
<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">61 yrs.</span>		<b>10. IF UNDER 1 YEAR</b> IF UNDER 24 HRS. Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">machine operation</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">mfg. straw hats</span>	
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U. S. A.</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Charles Milliken</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Mary White</span>	

<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">unknown</span>	<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">212-05-886601</span>	<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">Records: SPRING GROVE STATE HOSPITAL</span>
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<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">Pneumonia</span> DUE TO <span style="font-size: 1.5em;">Cardiovascular disease</span> Conditions, if any, which gave rise to immediate cause (b) <span style="font-size: 1.5em;">fracture left femur</span> (c) <span style="font-size: 1.5em;">fracture left femur</span> (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <span style="font-size: 1.2em;">Pt. fell while leaving bathroom on 8-25-60 at 10:15 a.m. apparently sustaining frac. of left femur.</span>
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <span style="font-size: 1.2em;">10:15 p.m.</span> <span style="font-size: 1.2em;">8-25</span> <span style="font-size: 1.2em;">1960</span>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">hospital</span>
<b>20f. (City or town)</b> <span style="font-size: 1.2em;">Catonsville</span> <b>(County)</b> <span style="font-size: 1.2em;">28, Maryland</span> <b>(State)</b>	

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.5em;">Geo M Kieffer</span> M.D.	<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">George M. Kieffer, M. D.</span>	

DATE SIGNED

<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">BURIAL</span>	<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">Nov. 15-1960</span>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Loughborough Cem</span>	<b>22d. LOCATION (City, town, or county)</b> <span style="font-size: 1.2em;">Frederick Ave</span> <b>(State)</b> <span style="font-size: 1.2em;">Md</span>
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<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">Thomas J. Kenny Inc 1600 Hollins St</span>	<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">DATE NOV 15 '60</span>
<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">A. Shaw &amp; Kane</span>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12303

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>3V01-4</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>Q.</b> Last <b>MOORE</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 28, 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCOTLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES MOORE</b>		14. MOTHER'S MAIDEN NAME <b>ISABELLA PAPE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>086-03-5831</b>	
17. INFORMANT <b>CLIN REC VAH BALTO 18 MD-FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERITONITIS</b> DUE TO <b>540.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PERFORATED GASTRIC PEPTIC ULCER</b> DUE TO <b>5</b> (c) <b>5 DAYS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>MARKED CEREBRAL ARTERIOSCLEROSIS</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 15, 1960</b> to <b>November 18, 1960</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 18, 1960</b> , and that death occurred at <b>9:10</b> a. m., from the causes and on the date stated above.			
22a. SIGNATURE <b>Carlton I. Halle</b>		22b. DATE SIGNED <b>11-19-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARLTON I. HALLE, M.D.</b>		22d. ADDRESS <b>VAH BALTO 18 MD - FT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>11-23-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ARLINGTON VIRGINIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. COOK-BLIGHT INC.</b>		25a. REC'D BY REGISTRAR <b>NOV 28 1960</b>	
ADDRESS <b>6009 Harford Road Baltimore 14, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

1934

CENTRAL OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12334

## CERTIFICATE OF DEATH

Reg. Dist. No. 12305

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Baltimore</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="float: right;">✓</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Catonsville</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">1mth12dys</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Baltimore</span> <span style="float: right;">3V01-4</span>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="font-size: 1.2em;">SPRING GROVE STATE HOSPITAL</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">1009 West Lombard Street</span>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.2em;">Catherine</span> Middle <span style="font-size: 1.2em;">Lavinia</span> Last <span style="font-size: 1.2em;">Moxley</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">November</span> Day <span style="font-size: 1.2em;">28</span> Year <span style="font-size: 1.2em;">19 60</span>			
5. SEX <span style="font-size: 1.2em;">female</span>	6. COLOR OR RACE <span style="font-size: 1.2em;">white</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">March 19, 1878</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">82</span> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">housework</span>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Unknown Walter F. Moxley</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Unknown</span>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <span style="font-size: 1.2em;">unknown</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">unknown</span>		17. INFORMANT Address <span style="font-size: 1.2em;">Records: SPRING GROVE STATE HOSPITAL</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Cardiac failure</span> DUE TO (b) <span style="font-size: 1.2em;">Arteriosclerotic cardiovascular disease</span> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <span style="float: right;">19</span>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <span style="font-size: 1.2em;">Nov. 26, 19 60</span> , to <span style="font-size: 1.2em;">Nov. 28, 19 60</span> , that I last saw the deceased alive on <span style="font-size: 1.2em;">Nov. 28, 19 60</span> , and that death occurred at <span style="font-size: 1.2em;">4:10 p. M.</span> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <span style="font-size: 1.2em;">Stella Wachslor</span> M.D.			ADDRESS (Street, city or town, state) <span style="font-size: 1.2em;">SPRING GROVE STATE HOSPITAL</span> DATE SIGNED <span style="font-size: 1.2em;">11-28-60</span>				
PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Stella Wachslor, M. D.</span>			<span style="font-size: 1.2em;">Catonsville 28, Maryland</span>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		22b. DATE THEREOF <span style="font-size: 1.2em;">12-3-60</span>		22c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">MT OLIVE CEM.</span>		22d. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE Md</span>	
23. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.2em;">Frank H. Seitz</span>			ADDRESS <span style="font-size: 1.2em;">814 W 36th St</span>		24a. REC'D BY REGISTRAR DATE <span style="font-size: 1.2em;">DEC 5 '60</span>	24b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em;">Arthur L. Harris</span>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2004

54 JOURNAL OF THE NATIONAL INDIAN HEALTH BOARD

12212

## CERTIFICATE OF DEATH

12306

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Lansdowne</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>142 Clyde Ave.</b>		d. STREET ADDRESS <b>142 Clyde Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>E.</b> Last <b>Murphy</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1885</b>
9. AGE (In years last birthday) yrs. <b>75</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles C. Troyer</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Miles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>----</b>	
INFORMANT <b>Edw. A. Murphy 4 Monmouth Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>42-2-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Arteriosclerotic CVD</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>sudden (1 hr) yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1959</b> to <b>Nov. 28, 1960</b> , that I last saw the deceased alive on <b>Nov. 27, 1960</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Levickas</b>		ADDRESS (Street, city or town, state) <b>5305 East Drive Baltimore - 27, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Levickas</b>		DATE SIGNED <b>DEC 5 '60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-1-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley-Cavanaugh F.H. Catonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 5 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Clara E. Kline</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BP 1

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1931

1931

MAINE  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Age at Death

Sex

Color

Marital Status

Occupation

Signature

Witness

Registrar

County

Town

State

Year

Month

Day

Hour

Minute

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12307

12335

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u> c. LENGTH OF STAY IN 1b <u>8 Days</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>200 Aisquith Street-Apt. C</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CHARLES</u> Middle <u>---</u> Last <u>MYERS</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>2</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Copper &amp; Brass</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Clayton Myers</u>				14. MOTHER'S MAIDEN NAME <u>Mary MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>D</u> Address <u>Clinical Records, VAH, Baltimore 18, Maryland</u> <u>FORT HOWARD DIVISION</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>OLD CEREBRAL INFARCT, RIGHT HEMISPHERE</u> (c) <u>MARKED CEREBRAL ARTERIOSCLEROSIS WITH BRAIN ATROPHY</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>
							<u>8 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (it (this hospital)) attended the deceased from <u>October 25, 1960</u> , to <u>November 2, 1960</u> , that (it) (we) last saw the deceased alive on <u>November 2, 1960</u> , and that death occurred at <u>12:50</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Frederick S. Donaldson</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11/2/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. DONALDSON, M.D.</u>				22d. ADDRESS <u>VAH, BALTIMORE 18 MD, FT. HOWARD DIVISION</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/4/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips</u> ADDRESS <u>1808 N. Monroe St. Baltimore 17, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

2459



12336

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12308

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pikesville</b>				c. LENGTH OF STAY IN 1b <b>X Pikesville 8, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 Hawthorne Ave., Pikesville 8</b>				d. STREET ADDRESS <b>18 Hawthorne Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Georgia May Myers</b>				4. DATE OF DEATH Month Day Year <b>November 28, 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 17, 1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>White Hall, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>White Hall, Md.</b>	
13. FATHER'S NAME <b>William Glenn</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Parks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Pikesville 8, Md Mr. Ernest B. Myers, 8 Hawthorne Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Arteriosclerotic heart disease</b> DUE TO (b) <b>several yrs</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (his hospital) attended the deceased from <b>May 1955</b> to <b>Nov 28, 1960</b> , that (I) (we) lost saw the deceased alive on <b>Nov 14, 1960</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Paul H Royse</b>				22b. DATE SIGNED <b>May 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Paul H Royse</b>				22d. ADDRESS <b>1403 Foley Lane, Pikesville 8 Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 1, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Boring, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Pikesville</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 2 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>							

STATE OF OHIO  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERIFICATE OF DEATH

12308

County of Franklin, State of Ohio

I, the undersigned, Registrar of the County of Franklin, State of Ohio,

do hereby certify that on the 12th day of December, 1928,

at Columbus, Ohio, died

John Doe, of the County of Franklin, State of Ohio,

being at the time of his death a resident of the County of Franklin,

State of Ohio, and that the cause of death was

MADE BY  
OFFICE OF THE  
REGISTERAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12309

12337

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yrl4mthdys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3101-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 3520 Hilton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary		Middle Neilson		Last Neilson		4. DATE OF DEATH Month November 3 Day 19 Year 60	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years lost birthday) 93? yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland (?)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. Arteriosclerosis, generalized and severe (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 30 1958 to Nov. 3 1960, that (I) (we) lost saw the deceased alive on Nov. 3 1960, and that death occurred at 2:20 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachsler		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov. 3, 1960			
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) 11/5/60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City, town, or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE R. E. D. L. J. Luck		ADDRESS 5305 Hayford Rd.		25a. REC'D BY REGISTRAR DATE NOV 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Knap	



12338

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrison</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harrison</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Reisterstown Rd.</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Cora Virginia Neudecker</i>		4. DATE OF DEATH Month Day Year <i>November 9 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12 July 1877</i>
9. AGE (In years lost birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife &amp; Nursing</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Andrew Drechsler</i>		14. MOTHER'S MAIDEN NAME <i>Angeline Long</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no.</i>		16. SOCIAL SECURITY NO. <i>215-32-8590</i>	
17. INFORMANT <i>Mrs John Basler</i>		Address <i>Garrison, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 arteriosclerotic heart disease</i> DUE TO (b) <i>just years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March</i> , 19 <i>55</i> , to <i>Nov. 7</i> , 1960, that I last saw the deceased alive on <i>Nov. 7</i> , 1960, and that death occurred at <i>6:10 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul H Royse</i>		ADDRESS (Street, city or town, state) <i>1403 FOLEY LANE</i>	
PHYSICIAN'S NAME (Type) <i>PAUL H ROYSE</i>		DATE SIGNED <i>9 Nov 60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/12/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Leisters Church Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Rural, Westminister, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. S. Myers, Jr.</i>		ADDRESS <i>Westminister Md.</i>	
24a. REC'D BY REGISTRAR <i>NOV 14 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Pharis</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)  
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TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12339

CERTIFICATE OF DEATH

12311

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PERRY HALL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PERRY HALL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4334 CHAPEL ROAD</u>		d. STREET ADDRESS <u>4334 CHAPEL ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>H.</u> Last <u>NEWMAN.</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 15, 1877</u>
9. AGE (In years lost birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>83</u> Days <u>83</u>	IF UNDER 24 HRS. Hours <u>83</u> Min. <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM RAUSCHENBACH.</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINA. UNKNOWN.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>BERTHA POLESNE.</u> Address <u>4334 CHAPEL RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic vascular</u> DUE TO <u>disease</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>37 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1956</u> to <u>Nov 14 1960</u> , that (I) (we) lost saw the deceased alive on <u>Nov 12 1960</u> , and that death occurred at <u>2 M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Rigley</u>		22b. DATE SIGNED <u>11-15-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR RICHARD RIGLEY</u>		22d. ADDRESS <u>1 W. OTERLEAVE BALTO MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Nov 17, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEN</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sassahn. Funeral Home</u>		25a. REC'D BY REGISTRAR <u>NOV 18 '60</u>	
ADDRESS <u>7401 Belair Road #6</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1951

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12340

CERTIFICATE OF DEATH

12312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3514 Rolling Road</b>				d. STREET ADDRESS <b>3514 Rolling Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>MILTON</b> Last <b>NORRIS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 11, 1870</b>	
9. AGE (In years lost birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mail Carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Norris</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Payne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-22-0619</b>		INFORMANT Address <b>A - Lizzie May Norris - 3514 Rolling Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic</b> <b>442X</b> DUE TO <b>Hypertensive C. V. Regard Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>10 years</b> DUE TO (c) <b>10 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19, 1954</b> to <b>Nov 29, 1960</b> , that I last saw the deceased alive on <b>Nov. 28, 1960</b> , and that death occurred at <b>3:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edwin L. Pierpont</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>8204 LIBERTY RD - BALTA 7, MD</b>			
PHYSICIAN'S NAME (Type) <b>Edwin L. Pierpont, M.D.</b>				8204 Liberty <del>XXXXXXX</del> Road			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/1/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>				24a. REC'D BY REGISTRAR <b>NOV 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Christina L. Howard</b>	

πλάνησις

12341

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balti more</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5435 Gradin Ave.</b>		d. STREET ADDRESS <b>6318 Reisterstown Road</b>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH C. Oden</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1893</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seton Institute</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. Long</b>		14. MOTHER'S MAIDEN NAME <b>Mary Waryick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>John Edward Oden 6318 Reisterstown Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart</b> DUE TO (c) <b>disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1957</b> to <b>Nov 1, 1960</b> that I last saw the deceased alive on <b>May 26, 1960</b> , and that death occurred at <b>11 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. H. Blumberg</b>		ADDRESS (Street, city or town, state) <b>7039 Liberty Rd.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Leonard H. Golombek</b>		<b>7039 Liberty Rd. Balto. y7, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 3, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Saint Andrews Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edna M. ...</b>		24a. REC'D BY REGISTRAR <b>3 '60</b>	
4600 Liberty Heights Ave. ELLSWORTH ARMA		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12344

CERTIFICATE OF DEATH

John T. Long  
Born [illegible]  
Died [illegible]  
Cause of Death [illegible]  
Buried [illegible]  
John T. Long  
Born [illegible]  
Died [illegible]  
Cause of Death [illegible]  
Buried [illegible]

*(Faint handwritten notes)*

John T. Long  
Born [illegible]  
Died [illegible]  
Cause of Death [illegible]  
Buried [illegible]  
John T. Long  
Born [illegible]  
Died [illegible]  
Cause of Death [illegible]  
Buried [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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12342

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12314

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>55</b> <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>218 Linden Ave.</b>		d. STREET ADDRESS <b>218 Linden Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Christina</b> First <b>Odgers</b> Middle Last		4. DATE OF DEATH Month <b>Nov.</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-22-1867</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Katherine MacDonald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. J. Wilson Odgers</b>		Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Cerebral Hemorrhage</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio-renal hypertensive disease</b> DUE TO (c) <b>10 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) <del>XXXX</del> attended the deceased from <b>Feb. 16</b> 19 <b>59</b> to <b>Nov. 8</b> 19 <b>60</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>Nov. 8</b> 19 <b>60</b> , and that death occurred at <b>6:40</b> <b>P.M.</b> causes and on the date stated above.			
22a. SIGNATURE <b>T.N. Wilson</b>		22b. DATE SIGNED <b>Nov. 9, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>T.N. Wilson</b>		22d. ADDRESS <b>617 W. 40th St. Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-11-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

Balto. 12, Md.

15314

CONTINGENT OF DEPT.

15315

1

CHIEF

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12315

Reg. Dist. No.

12205

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Dundalk</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3013 Dundalk Ave.</u>				d. STREET ADDRESS <u>3013 Dundalk Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <u>MARGARET ELEANOR O'GRADY</u>				<b>4. DATE OF DEATH</b> <span style="float: right;">Month Day Year</span> <u>November 14, 19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1913</u>	
9. AGE (In years last birthday) <u>46 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY  		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>James T. Shea</u>				14. MOTHER'S MAIDEN NAME <u>Flora Grimes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO.  		17. INFORMANT <u>Thomas W. O'Grady 3013 Dundalk Ave.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <u>Strangulation by Hanging</u>            974X DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____            DUE TO (c) _____         </div> <div style="width: 15%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH  <u>10 min</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <span style="float: right;">19</span>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-16-60</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack Collins, M.D.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>11/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Colgate, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home Dundalk, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please etc.  
 TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please etc.  
 TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please etc.

1871

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1904

NAME OF DECEASED: JOHN J. BROWN

AGE: 45 YEARS

SEX: MALE

RACE: WHITE

DATE OF DEATH: 1904

PLACE OF DEATH: NEW YORK

CAUSE OF DEATH: HEART DISEASE

DATE OF EXAMINATION: 1904

SIGNATURE OF EXAMINER: JOHN J. BROWN

OFFICE OF THE EXAMINER: NEW YORK

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12316

12343

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u>		c. LENGTH OF STAY IN 1b <u>34 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u> d. STREET ADDRESS <u>11 Greenwood Road</u>	
3. NAME OF DECEASED (Type or print) <u>Richard Colley Oler</u>		4. DATE OF DEATH <u>Nov 27 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1875</u>
9. AGE (In years last birthday) <u>85 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter-painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>contractors</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Oler</u>		14. MOTHER'S MAIDEN NAME <u>William Oler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-24-9872</u>	
17. INFORMANT <u>William Oler</u>		Address <u>Pikesville 8, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 26, 1952</u> to <u>Nov 27, 1960</u> , that I last saw the deceased alive on <u>Nov 26, 1960</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Williams</u>		ADDRESS (Street, city or town, state) <u>1632 Reisterstown Road</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>		DATE SIGNED <u>Pikesville 8, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov. 30, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		ADDRESS <u>Pikesville 8, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thoma</u>	
DATE <u>NOV 30 '60</u>			

13318

CERTIFICATE OF DEATH

13318

For Use By

1. PLACE OF DEATH		2. MANNER OF DEATH	
3. PLACE OF BIRTH		4. PLACE OF DEATH	
5. PLACE OF BIRTH		6. PLACE OF DEATH	
7. PLACE OF BIRTH		8. PLACE OF DEATH	
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13. PLACE OF BIRTH		14. PLACE OF DEATH	
15. PLACE OF BIRTH		16. PLACE OF DEATH	
17. PLACE OF BIRTH		18. PLACE OF DEATH	
19. PLACE OF BIRTH		20. PLACE OF DEATH	
21. PLACE OF BIRTH		22. PLACE OF DEATH	
23. PLACE OF BIRTH		24. PLACE OF DEATH	
25. PLACE OF BIRTH		26. PLACE OF DEATH	
27. PLACE OF BIRTH		28. PLACE OF DEATH	
29. PLACE OF BIRTH		30. PLACE OF DEATH	
31. PLACE OF BIRTH		32. PLACE OF DEATH	
33. PLACE OF BIRTH		34. PLACE OF DEATH	
35. PLACE OF BIRTH		36. PLACE OF DEATH	
37. PLACE OF BIRTH		38. PLACE OF DEATH	
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63. PLACE OF BIRTH		64. PLACE OF DEATH	
65. PLACE OF BIRTH		66. PLACE OF DEATH	
67. PLACE OF BIRTH		68. PLACE OF DEATH	
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73. PLACE OF BIRTH		74. PLACE OF DEATH	
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77. PLACE OF BIRTH		78. PLACE OF DEATH	
79. PLACE OF BIRTH		80. PLACE OF DEATH	
81. PLACE OF BIRTH		82. PLACE OF DEATH	
83. PLACE OF BIRTH		84. PLACE OF DEATH	
85. PLACE OF BIRTH		86. PLACE OF DEATH	
87. PLACE OF BIRTH		88. PLACE OF DEATH	
89. PLACE OF BIRTH		90. PLACE OF DEATH	
91. PLACE OF BIRTH		92. PLACE OF DEATH	
93. PLACE OF BIRTH		94. PLACE OF DEATH	
95. PLACE OF BIRTH		96. PLACE OF DEATH	
97. PLACE OF BIRTH		98. PLACE OF DEATH	
99. PLACE OF BIRTH		100. PLACE OF DEATH	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Balto.</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Balt 15</i>						c. LENGTH OF STAY IN 1b <i>4 1/2 yrs</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>6710 Brighton Ave</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>HERMAN SELF</i>						4. DATE OF DEATH Month <i>Nov</i> Day <i>28</i> Year <i>1960</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 7, 1886</i>		9. AGE (in years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Street Car Operator, Balto. Transit</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>va.</i>		11. BIRTHPLACE (State or foreign country) <i>va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Wesley Oliff</i>						14. MOTHER'S MAIDEN NAME <i>Sarah Croston</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>none.</i>						16. SOCIAL SECURITY NO. <i>215-09-3637</i>					
17. INFORMANT <i>Lena Oliff (wife)</i>						Address <i>Same.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>											
DUE TO (b) <i>Hypertensive arteriosclerotic C.V. Disease</i>											
DUE TO (c) <i>Coronary Artery Disease</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>none.</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>none.</i>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none.</i>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>none.</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none.</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>MD</i>		(State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>D.D. Caples</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) <i>Balto - 17, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/1/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i>		22d. LOCATION (City, town, or country) <i>Baltimore, Maryland</i>		(State) <i>MD</i>			
23. FUNERAL DIRECTOR <i>Wm J. Tischer</i>						24a. REC'D BY REGISTRAR <i>NOV 29 '60</i>					
ADDRESS <i>Balto - 17, Md.</i>						24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>					

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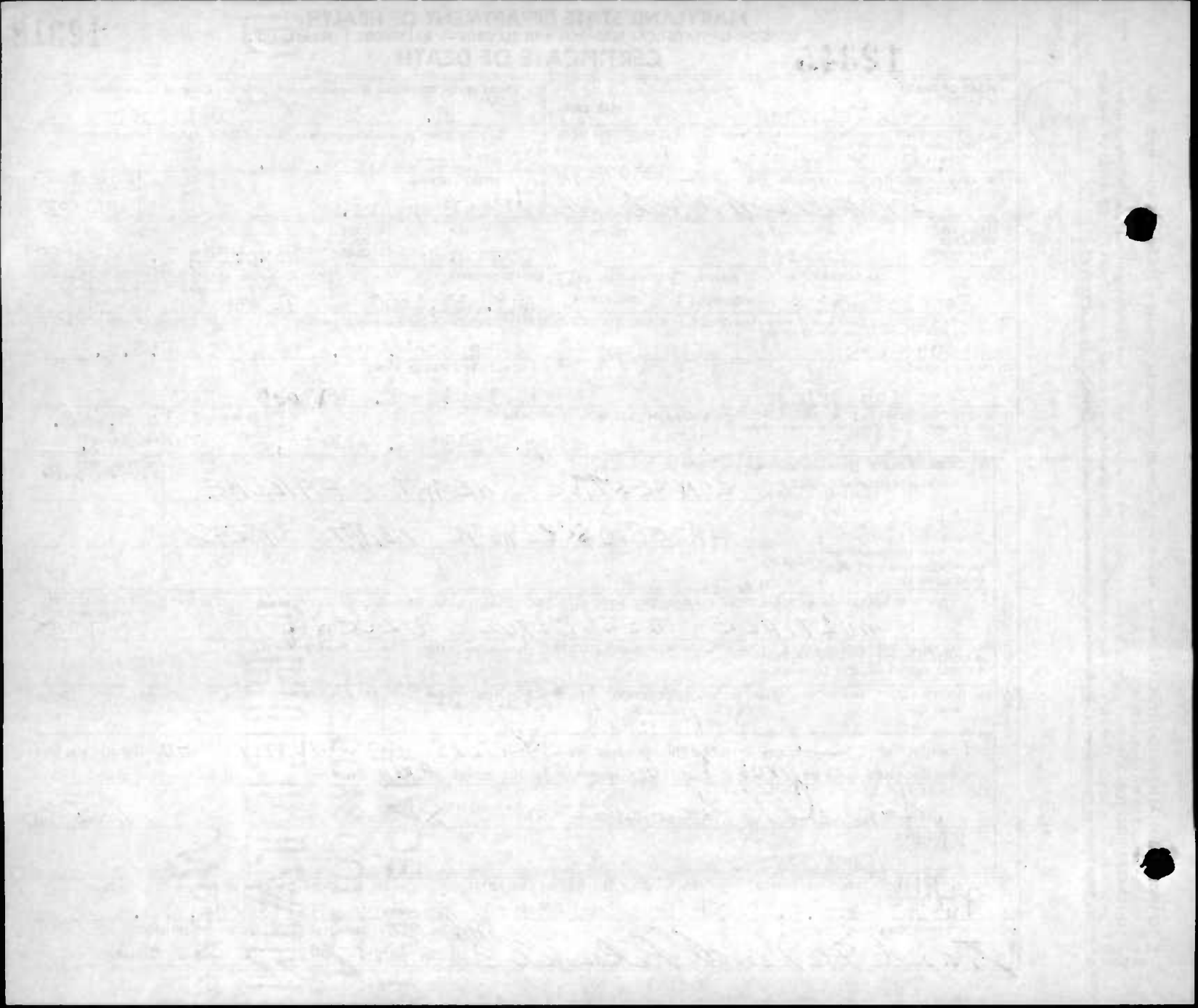
1811

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
12318  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>27 Walker Ave. Pikesville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Ortman</u> Last <u>Ortman</u>		4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1869</u>
9. AGE (In years lost birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hancock, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeremiah Ortman</u>		14. MOTHER'S MAIDEN NAME <u>Louise K. Holbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Stella R. Abbott</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MULTIPLE DECUBITUS ULCERS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>SEPT. 15, 1959</u> to <u>NOV. 1, 1960</u> , that (I) (we) last saw the deceased alive on <u>NOV. 1, 1960</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Samuel P. Scalia</u>		22b. DATE SIGNED <u>11-2-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Samuel P. Scalia</u>		22d. ADDRESS <u>Pikesville 8, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 3, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		25c. ADDRESS <u>Pikesville 8, Md.</u>	



12346

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>																													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Maryland</u>										c. LENGTH OF STAY IN 1b <u>10 days</u>																													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk 22</u>																													
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										d. STREET ADDRESS <u>1 1958 Ormand Road</u>																													
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>---</u> Last <u>PERRONE</u>										4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1960</u>																													
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>March 31, 1890</u>			9. AGE (In years last birthday) <u>70</u> yrs.			IF UNDER 1 YEAR Months Days Hours Min.			IF UNDER 24 HRS.																					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>										10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>										11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>										12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>John Perrone</u>										14. MOTHER'S MAIDEN NAME <u>Ida Loveless</u>																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW-1</u>										16. SOCIAL SECURITY NO. <u>218-18-5898</u>										17. INFORMANT <u>Clinical Records</u> Address <u>VAH, Baltimore, Md. - FORT HOWARD DIVISION</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>581.0 PORTAL CIRRHOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>EDEMA OF LUNGS</u> (c) <u>BENIGN PROSTATIC HYPERTROPHY</u>										INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>2 DAYS</u>																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 15, 1960</u> to <u>Nov. 25, 1960</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>Nov. 25, 1960</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.																																							
22a. SIGNATURE <u>George C. McElfatrick, M.D.</u> M.D.										ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>11/26/60</u>																													
22c. PHYSICIAN'S NAME (Type) <u>GEORGE C. McELFATRICK, M.D.</u>										22d. ADDRESS <u>VAH, Baltimore, Md. - Fort Howard Division</u>																													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										23b. DATE THEREOF <u>11-28-60</u>										23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cemetery</u>										23d. LOCATION (City, town, or county) (State) <u>Dundalk 22, Maryland</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>										ADDRESS <u>6009 Harford Rd. Baltimore 14, Maryland</u>										25a. REC'D BY REGISTRAR DATE <u>NOV 29 '60</u>										25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>									

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1931

CERTIFICATE OF DEATH

1931

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1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Signature of informant



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

12347

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12320

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Larchmont</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Larchmont 7</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2514 Poplar Drive</b>		d. STREET ADDRESS <b>2514 Poplar Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LESTER</b> Middle <b>M.</b> Last <b>PHOEBUS, SR.</b>		4. DATE OF DEATH Month <b>November</b> Day <b>16</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30, 1875</b>
9. AGE (In years lost birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Insurance Underwriter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balbot County, Maryland</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Wilbur ----</b>		14. MOTHER'S MAIDEN NAME <b>Mary P. Kelly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT Address <b>Mr. William R. Buchanan-38 W. Chesapeake Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Atherosclerosis - Complete</b> DUE TO <b>Heart Block</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Calific Arterial Disease</b> (b) <b>Calific Arterial Disease</b> DUE TO <b>Calific Arterial Disease</b> (c) <b>Calific Arterial Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>22 yrs</b> <b>22 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>5-8-1938</b> to <b>11-16-1960</b> that (I) (we) last saw the deceased alive on <b>11-15-1960</b> , and that death occurred at <b>8 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Leon Ashman</b>		22b. DATE SIGNED <b>11-18-60</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>5907 Surgen Oak Ave #7</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/19/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Ticken</b> ADDRESS <b>Beltsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 21 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Wm. J. Ticken</b>	

13384

CERTIFICATE OF DEATH

13344

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN. 10, 1915	
AGE		SEX	
65		M	
PLACE OF BIRTH		OCCUPATION	
NEW YORK		FARMER	
CAUSE OF DEATH		PLACE OF DEATH	
HEART DISEASE		HOME	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
J. H. HARRIS		J. H. HARRIS	
DATE		TIME	
JAN. 10, 1915		10:00 AM	
LOCALITY		COUNTY	
NEW YORK		NEW YORK	
STATE		COUNTRY	
NEW YORK		UNITED STATES	

1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
12348

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12321

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>				c. LENGTH OF STAY IN 1b <u>18 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>607 Reisterstown Rd., Pikesville</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>E.</u> Last <u>Poe</u>				4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 21, 1888</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pikesville, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William G. Rogers</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Keys</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Andrew Poe, 607 Reisterstown Rd.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Hypertension &amp; Arteriosclerosis</u> DUE TO (c) <u>Hemiplegia - left sided</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>per 3 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>per 3 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>per 3 yrs</u>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>11-11-60</u> 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>Pikesville, Md.</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1957</u> to <u>11-11-1960</u> that (I) (we) lost saw the deceased alive on <u>11-10-60</u> and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James G. Saffell</u>				22b. DATE SIGNED <u>11-12-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell MD</u>				22d. ADDRESS <u>Reisterstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 14, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mays Chapel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Pearl, Pikesville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

12345

DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
STATE OF NEW YORK  
CERTIFICATE OF DEATH

12345

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of death: *Jan 15 1950*  
5. Place of death: *New York City*  
6. Cause of death: *Heart Disease*  
7. Signature of physician: *Dr. J. Smith*  
8. Signature of registrar: *John Doe*  
9. Date of registration: *Jan 15 1950*  
10. Place of registration: *New York City*

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12349

CERTIFICATE OF DEATH

12322

Item 9 Film 277 12-21-60 et

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>25yr5mth11dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		<b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>314 South Register Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Helen</b>		Middle <b>G.</b>		Last <b>Ponicki</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1894</b>		9. AGE (In years last birthday) <b>66 66 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Roh Grzegozewski</b>			14. MOTHER'S MAIDEN NAME <b>Margaret ?</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records; SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 16, 19 60</b> to <b>Nov. 21, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 21, 19 60</b> , and that death occurred at <b>11-21-60</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Stella Wachslar</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-21-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/25/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Grzegozewski</b>		ADDRESS <b>1930 Eastern Ave</b>		25a. REC'D BY REGISTRAR <b>NOV 28 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Edmund S. K...</b>	

MEDICAL CERTIFICATION

1958

STATE OF TEXAS

1958

IN SENATE,  
January 1, 1958.  
REPORT  
OF THE  
COMMISSIONER OF THE  
GENERAL LAND OFFICE  
TO THE  
LEGISLATIVE COMMITTEE ON  
LANDS AND MINES  
FOR THE YEAR  
1957.



12350

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>				c. LENGTH OF STAY IN 1b <b>28</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick and Oella Ave.</b>				d. STREET ADDRESS <b>Frederick and Oella Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAISY</b> Middle <b>VIRGINIA</b> Last <b>POTTS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1884</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>A Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Potts</b>				14. MOTHER'S MAIDEN NAME <b>Mary Cogle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		INFORMANT Address <b>Charles L. Potts, Frederick and Oella Ave. Catonsville 28, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory failure</b> 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Degeneration</b> DUE TO (c) <b>Hypertrophy &amp; failure</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b> INTEVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1958</b> , to <b>Nov 1960</b> that I last saw the deceased alive on <b>1 Nov 1960</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>4605 Edmondy Ave 3 Nov 60</b>							
ACTUAL SIGNATURE <b>William J. Bryson MD</b>		M.D. <b>4605 Edmondy Ave 3 Nov 60</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-4-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bolivar, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 4 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

1937

State of New York

County of New York

City of New York

Decem 1937

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1937

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12351

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12324

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>43 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> <b>22-12-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>603 W. Overcircle</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES W. PRICE</b>				4. DATE OF DEATH Month Day Year <b>November 26 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 28, 1934</b>	
9. AGE (In years lost birthday) <b>26 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Basket Maker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Basket Company</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>McKinley Price</b>				14. MOTHER'S MAIDEN NAME <b>Mary R. Price</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>PL 28</b>				16. SOCIAL SECURITY NO. <b>214-30-9487</b>		17. INFORMANT Address <b>Clin. Records, Vet. Adm. Hosp, Balto. Md. Ft. Howard Div</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN ABSCESS</b> DUE TO <b>342X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>MENINGITIS</b> DUE TO (c) <b>EDEMA OF LUNGS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>54 DAYS</b> <b>50 DAYS</b> <b>2 DAYS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 14, 1960</b> to <b>November 26, 1960</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 26, 1960</b> , and that death occurred at <b>7:50 am</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George C. McElpatrick</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <b>EE</b>		22b. DATE SIGNED <b>11/26/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK</b>				22d. ADDRESS <b>VAH, BALTO. MD. FT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-30-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Head of Creek</b>		23d. LOCATION (City, town, or county) (State) <b>Head of Creek md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>West Funeral Home, 130 2nd St. Salisbury, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 30 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

1331

**1**  
**FOR STATE**  
**HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**12352**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**12325**

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balt</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>Middle River</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>283 Vandermast Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Worth Jennings Pryor</b>				4. DATE OF DEATH <b>Nov 26/60</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 29 1901</b>	
9. AGE (in years last birthday) <b>59</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>maintainance</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ira Pryor</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>Joseph A Pryor 7886 Harold Ave 22Md</b>			
17. INFORMANT <b>Joseph A Pryor 7886 Harold Ave 22Md</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <b>420.1</b> DUE TO <b>CORONARY Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Hypertensive C-V-D Disease</b> (a) (b) (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M B Davis</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Melvin B Davis M.D. 6800 Morningson Road</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>Nov 29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Cem</b>	
22d. LOCATION (City, town, or country) <b>Howard Co</b>				22e. REGISTRAR'S SIGNATURE <b>11/27/60 =</b>			
23. FUNERAL DIRECTOR <b>Ullrich Funeral Home 2112 Dundalk Ave</b>				24a. REC'D BY REGISTRAR <b>NOV 28 '60</b>			

454

1



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO MD.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AUGSBURG Home</u>		d. STREET ADDRESS <u>421 W. LAFAYETTE</u>	
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>PUMPHREY</u> Last <u>PUMPHREY</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>13TH</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9/10/1884</u>
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>BALTO MD.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>DANIEL F. STRUBE</u>	
14. MOTHER'S MAIDEN NAME <u>O'Doherty</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>RECORDS AUG. HOME CAMPFIELD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1) Arterio-Sclerotic Heart Disease</u> DUE TO <u>420-0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2) Broncho-Pneumonia</u> DUE TO <u>(3) -</u> (c) <u>Generalized Arterio-Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 18, 1960</u> to <u>Nov 13, 1960</u> , that I last saw the deceased alive on <u>Nov 13, 1960</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4108 Liberty Hts. Balto - Md. 11-15-60</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		<u>4108 Liberty Hts. Balto - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>11/16/60</u>	<u>WESTERN Cem</u>	<u>BALTO.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>6067 Hayford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1888

DEPARTMENT OF HEALTH

1888



*[Faint, illegible text, likely bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12354

12327

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>Pikesville 8</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>607 Field Road</b>		d. STREET ADDRESS <b>607 Field Road</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>T.</b> Last <b>REED</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 23, 1901</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ass't Vice-President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. National Bank Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Reed</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. -----</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-6339</b>	
17. INFORMANT <b>Mrs. Eleanor D. Reed-607 Field Road #8</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>(1) Primary Carcinoma of Pancreas</b> DUE TO <b>157X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(2) Generalized carcinomatosis of Abdominal cavity</b> DUE TO (c) <b>3 months</b> - <b>3 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 3, 1955</b> to <b>Nov. 1, 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct. 30, 1960</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl L. Chambers</b>		22b. DATE SIGNED <b>11/2/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		22d. ADDRESS <b>4108 Liberty Hts. Balto. 7 - Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/3/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichenor</b>		25a. REC'D BY REGISTRAR <b>NOV 2 '60</b>	
ADDRESS <b>Balto - 17, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Orlino S. Hanna</b>	



12355

## CERTIFICATE OF DEATH

12328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Washington</b>				c. LENGTH OF STAY IN 1b <b>9</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6070 Falls Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alfred</b> Middle <b>P.</b> Last <b>Rehbein</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14, 1875</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min.	IF UNDER 24 HRS. Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Adam T. Rehbein</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Haines</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-32-2771</b>		INFORMANT <b>Mrs. Margaret R. Baker</b>		Address <b>6070 Falls Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Intestine</b> DUE TO (b) <b>Myo. Carditis - Endocarditis</b> DUE TO (c) <b>Chronic Nephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>15-year</b> <b>year</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1940</b> to <b>May 1960</b> that I last saw the deceased alive on <b>Nov 23</b> , 19 <b>60</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2824 St. Paul St</b> DATE SIGNED ACTUAL SIGNATURE <b>Herbert M. Foster</b> M.D. PHYSICIAN'S NAME (Type) <b>HERBERT M. FOSTER M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 26, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Warren, Baltimore Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b> <b>3631 Falls Road</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Anthony S. Haines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938

CERTIFICATE OF DEATH

15373

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DECEASED

DATE OF DEATH

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TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12356

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12329

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>19 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> d. STREET ADDRESS <b>Route #2, Fairview Beach</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>R.</b> Last <b>REIMSNIDER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 27, 1893</b>	9. AGE (In years lost birthday) yrs. <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Dorsey, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Daniel Reimsnider</b>		14. MOTHER'S MAIDEN NAME <b>Emma Boston</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>Fort Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTROPHY AND DILATATION OF HEART</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH +</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old myocardial Infarction</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, BALTO. 18 MD FORT HOWARD DIVISION</b>	
20f. (City or town) <b>VAH, BALTO. 18 MD FORT HOWARD DIVISION</b>		20g. (County) <b>Howard County, Maryland</b>		20h. (State) <b>Maryland</b>	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>October 14, 1960</b> to <b>November 2, 1960</b> , that <del>he</del> (we) last saw the deceased alive on <b>11/2/ 1960</b> , and that death occurred at <b>p.</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <i>Frederick S. Donaldson</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18 MD FORT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5th Nov, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>	
23d. LOCATION (City, town, or county) <b>Howard County, Maryland</b>		23e. (State) <b>Maryland</b>		23f. (Country) <b>U. S. A.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Richard V. Singleton</i>		ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 7 '60</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>					

# STATE OF TEXAS

1835

County of ... State of Texas  
 I, the undersigned, Clerk of the County of ... do hereby certify that the within and foregoing is a true and correct copy of the ... as the same appears from the records of said County.

Witness my hand and the seal of said County at the City of ... this ... day of ... 1835.

Attest:  
 My hand and the seal of said County at the City of ... this ... day of ... 1835.

CLERK OF THE COUNTY OF ...

...

...

...

...

## CERTIFICATE OF DEATH

Reg. Dist. No.

12330

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>29 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hosp.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> <b>3701-4</b>	
f. STREET ADDRESS <b>364 Mt. Olivet Lane</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LOUISE</b> Last <b>REIN</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 17, 1879</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR: Months <b>81</b> Days <b>19</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frederick Rein</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH Bruehl</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Hospital Record</b>	
17. INFORMANT <b>Hospital Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>11 years.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 1960</b> , to <b>Nov. 19, 1960</b> , that I last saw the deceased alive on <b>Nov 19, 1960</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. I. Holmondeley</b> M.D.		ADDRESS (Street, city or town, state) <b>11/19/60</b>	
DATE SIGNED		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>H. I. HOLMONDELEY</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 23, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cem. Balto.</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Timmon Schuch</b> ADDRESS <b>3512 Frederick Ave. (29)</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 22 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12380

12380

PLACE OF DEATH HOME		MARYLAND	
SEX AND AGE Male 65		DATE OF DEATH 12/15/1918	
OCCUPATION Farmer		PLACE OF BIRTH Maryland	
MARITAL STATUS Married		COLOR White	
CAUSE OF DEATH Influenza		MEDICAL HISTORY None	
PLACE OF INTERMENT Home		SIGNATURE OF DECEASED [Signature]	
SIGNATURE OF WITNESS [Signature]		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF CLERK [Signature]		SIGNATURE OF REGISTRAR [Signature]	

This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. The certificate is to be filled out in duplicate, one copy to be filed in the office of the Registrar and the other copy to be filed in the office of the physician or other person authorized by the State Department of Health.

1. PLACE OF DEATH o. COUNTY <i>Baltimore 19</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>as</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Pt.</i>	c. LENGTH OF STAY IN 1b <i>38 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7317 N. DAKOTA AVE</i>		d. STREET ADDRESS <i>1 #1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>HERMAN JACOB RESSLER</i>		4. DATE OF DEATH Month Day Year <i>NOV. 30 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 2 1867</i>
9. AGE (In years last birthday) <i>93 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>	11. BIRTHPLACE (State or foreign country) <i>Butler Co. Iowa</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John B. Ressler</i>	
14. MOTHER'S MAIDEN NAME <i>Nancy Margartz</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Jura Lewis</i> Address <i>address as in #1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>12 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1932</i> to <i>Nov. 30, 1960</i> , that I last saw the deceased alive on <i>Nov. 29, 1960</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis N. Tollin</i> M.D.		ADDRESS (Street, city or town, state) <i>6908 NORTH POINT Rd</i> DATE SIGNED <i>11/30/60</i>	
PHYSICIAN'S NAME (Type) <i>LOUIS N. TOLLIN MD</i>		<i>BALTIMORE-19-MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-3-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Oaklawn</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook Blight Inc.</i>		ADDRESS <i>6009 Harford Rd. Balto.</i>	24a. REC'D BY REGISTRAR <i>DEC 6 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>







TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12359

12332

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b> c. LENGTH OF STAY IN lb <b>105 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>31 014</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5800</b> <b>4337 York Road (12) Baltimore</b> d. STREET ADDRESS <b>5800</b> <b>4337 York Road (Balto. 12)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FERDINAND F. RITTER</b>				4. DATE OF DEATH Month Day Year <b>November 8 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 22, 1895</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber - Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber Shop</b>		11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank Ritter</b>				14. MOTHER'S MAIDEN NAME <b>Dora Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 215-05-0228</b>		17. INFORMANT <b>Clinical Records</b> <b>VAH, Baltimore 18, Maryland, Ft. Howard Division</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SQUAMOUS CARCINOMA, PHARYNX WITH ABSCESS FORMATION ON THE SOFT PART OF THE NECK</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>EDEMA OF THE LUNGS</b> DUE TO (c) <b>8 MONTHS UNKNOWN</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>July 26 12:45</b> to <b>November 8, 1960</b> , that (X) (we) last saw the deceased alive on <b>November 8, 1960</b> , and that death occurred at <b>A. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Fredrick S. Donaldson</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE <b>11/8/60</b>	
22c. PHYSICIAN'S NAME (Type or print) <b>FREDERICK S. DONALDSON, M.D.</b>				22d. ADDRESS <b>X VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 11, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran 3000 E. Baltimore St., Balto.</b>				25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Archie L. House</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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12360												MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH												12333			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND												2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>												c. LENGTH OF STAY IN 1b <b>Towson 4 -</b>															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Conval. Home</b>												d. STREET ADDRESS <b>7734 Greenview Terrace</b>												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>ROEDEL</b>												4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>19 60</b>															
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 2, 1883</b>				9. AGE (In years lost birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Vice-President</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Hecht Company</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY?													
13. FATHER'S NAME <b>Louis Roedel</b>						14. MOTHER'S MAIDEN NAME <b>Katherine Heizlering</b>																					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>213-01-0831A</b>				17. INFORMANT <b>Mrs. Emma L. Roedel-7734 Greenview Terrace #4</b>						Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>4 20.1</b> IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Chronic Congestive Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic C-V Disease</b> (c) <b>Marked Cardiac &amp; Aortic Enlargement</b>												INTERVAL BETWEEN ONSET AND DEATH <b>unmed</b> <b>1 1/2 yrs</b> <b>5 yrs</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1960</b> to <b>11/17 1960</b> that (I) <del>was</del> last saw the deceased alive on <b>11/17 1960</b> and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.																											
22a. SIGNATURE <b>Victor A. Zeng</b>						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/18/60</b>															
22c. PHYSICIAN'S NAME (Type) <b>Victor A. Zeng</b>						22d. ADDRESS <b>1102 E. Joyce Rd. Towson Md</b>																					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/19/60</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>															
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichner</b>						ADDRESS <b>17. Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 21 '60</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>																	

CERTIFICATE OF DEATH

12340

12340

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
AGE AT DEATH  
SEX  
RACE  
RELIGION  
EDUCATION  
OCCUPATION  
MARRIAGE  
SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
REMARKS

*[Handwritten notes and signatures in the lower half of the page, including names and dates.]*

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Balto.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.Co.</b>			c. LENGTH OF STAY IN 1b <b>20 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.Co.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1317 Taylor Ave</b>					d. STREET ADDRESS <b>1317 Taylor Ave</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Rolf</b> Last					4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1960</b>				
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 5, 1904</b>		9. AGE (In years last birthday) <b>56</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer, Bethlehem Steel Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Rolf</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>278-03-5631</b>		17. INFORMANT Address <b>Mrs Vernon Kane, 2500 Anders Rd.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>162.1</b> IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/5</b> 19 <b>60</b> to <b>11/4</b> 19 <b>60</b> ; that (I) (we) last saw the deceased alive on <b>11/4</b> 19 <b>60</b> and that death occurred at <b>10:30</b> P. M. from the causes and on the date stated above.									
22a. SIGNATURE <b>E. Gordon Grau</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>E. GORDON GRAU MD</b>					22d. ADDRESS <b>8523 Fork Raven Blwy</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 7/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemt</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Fun. Dir. 4101 Edmondson Ave.</b>					25a. REC'D BY REGISTRAR <b>NOV 9 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Clint S. House</b>		

15384

CERTIFICATE OF DEATH

15381

JOHN TAYLOR

JOHN TAYLOR

JOHN TAYLOR

JOHN TAYLOR

JOHN TAYLOR

JOHN TAYLOR

JOHN TAYLOR

JOHN TAYLOR

JOHN TAYLOR

JOHN TAYLOR



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12335  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>2yr8mthldy</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Roosz</u> Last <u>Roosz</u>				4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-11-75</u> <u>June 10, 1877</u>	
9. AGE (In years last birthday) <u>85 (83)</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u> Hours <u>15</u> Min.		11. IF UNDER 24 HRS. Months <u>5</u> Days <u>10</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Budapest</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Hungary</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1, 1960</u> to <u>Nov. 5, 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov. 5, 1960</u> and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE THEREOF <u>11-11-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Brownlee, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCall Funeral Home 150 E. Jct. Ave. DHD</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

1985

CERTIFICATE OF DEATH

1985



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
12363  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12336

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>3201-4</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4y6mth14dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Ross</b> Last <b>Ross</b>		4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 10, 1903</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife - waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Greenberg</b>		14. MOTHER'S MAIDEN NAME <b>Rose Londer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Cardiac failure</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 26, 1956</b> to <b>Nov. 10, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 10, 1960</b> , and that death occurred at <b>3:58 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b>		22b. DATE SIGNED <b>11-10-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral</b>		23b. DATE THEREOF <b>11-13-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington</b>		23d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur A. Hester</b>			

STATE OF OHIO  
COUNTY OF [illegible]  
CITY OF [illegible]

1891

X

1891

1891







MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12338

12365

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b> c. LENGTH OF STAY IN 1b <b>40 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Baltimore (28)</b> d. STREET ADDRESS <b>421 Whitfield Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANTHONY</b> Middle <b>G.</b> Last <b>SACKALOSKY</b>				4. DATE OF DEATH Month <b>November</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 10, 1899</b>	
9. AGE (In years lost birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>61</b> Days <b>16</b> Hours <b>16</b> Min.		IF UNDER 24 HRS. Months <b>61</b> Days <b>16</b> Hours <b>16</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegraph Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Western Union</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Sackalosky</b>				14. MOTHER'S MAIDEN NAME <b>Veronica Rutkowsky</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>				16. SOCIAL SECURITY NO. <b>218-05-5887</b>		17. INFORMANT <b>Clinical Records</b> Address <b>VAH, Baltimore 18</b> <b>FORT HOWARD DIVISION Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE RIGHT LUNG WITH METASTASIS TO THE CERVICAL AND SCALNE LYMPH NODES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>MARKED ACTELECTASIS OF THE RIGHT LUNG</b> (b) <b>PERICARDITIS</b> (c) <b>PERICARDITIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>14 Months</b> Unknown Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from <b>Oct. 7 1960</b> to <b>Nov. 16 1960</b> , that (X) (we) lost saw the deceased alive on <b>Nov. 16 1960</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Frederick S. Donaldson</b> M.D.				22b. DATE <b>11/16/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>				22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 21-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas J. Kenny, Inc. 1600 Hollins St., Balto. Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 18 60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1988

CERTIFICATE OF DEATH

1988

1

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Date of birth: \_\_\_\_\_

4. Date of death: \_\_\_\_\_

5. Place of death: \_\_\_\_\_

6. Cause of death: \_\_\_\_\_

7. Signature of medical officer: \_\_\_\_\_

8. Signature of registrar: \_\_\_\_\_

9. Signature of informant: \_\_\_\_\_

10. Date of registration: \_\_\_\_\_

11. Place of registration: \_\_\_\_\_

12. Name of registrar: \_\_\_\_\_

13. Name of informant: \_\_\_\_\_

14. Name of medical officer: \_\_\_\_\_

15. Name of registrar: \_\_\_\_\_

16. Name of informant: \_\_\_\_\_

17. Name of medical officer: \_\_\_\_\_

18. Name of registrar: \_\_\_\_\_

19. Name of informant: \_\_\_\_\_

20. Name of medical officer: \_\_\_\_\_

21. Name of registrar: \_\_\_\_\_

22. Name of informant: \_\_\_\_\_

23. Name of medical officer: \_\_\_\_\_

24. Name of registrar: \_\_\_\_\_

25. Name of informant: \_\_\_\_\_

26. Name of medical officer: \_\_\_\_\_

27. Name of registrar: \_\_\_\_\_

28. Name of informant: \_\_\_\_\_

29. Name of medical officer: \_\_\_\_\_

30. Name of registrar: \_\_\_\_\_

31. Name of informant: \_\_\_\_\_

32. Name of medical officer: \_\_\_\_\_

33. Name of registrar: \_\_\_\_\_

34. Name of informant: \_\_\_\_\_

35. Name of medical officer: \_\_\_\_\_

36. Name of registrar: \_\_\_\_\_

37. Name of informant: \_\_\_\_\_

38. Name of medical officer: \_\_\_\_\_

39. Name of registrar: \_\_\_\_\_

40. Name of informant: \_\_\_\_\_

41. Name of medical officer: \_\_\_\_\_

42. Name of registrar: \_\_\_\_\_

43. Name of informant: \_\_\_\_\_

44. Name of medical officer: \_\_\_\_\_

45. Name of registrar: \_\_\_\_\_

46. Name of informant: \_\_\_\_\_

47. Name of medical officer: \_\_\_\_\_

48. Name of registrar: \_\_\_\_\_

49. Name of informant: \_\_\_\_\_

50. Name of medical officer: \_\_\_\_\_

51. Name of registrar: \_\_\_\_\_

52. Name of informant: \_\_\_\_\_

53. Name of medical officer: \_\_\_\_\_

54. Name of registrar: \_\_\_\_\_

55. Name of informant: \_\_\_\_\_

56. Name of medical officer: \_\_\_\_\_

57. Name of registrar: \_\_\_\_\_

58. Name of informant: \_\_\_\_\_

59. Name of medical officer: \_\_\_\_\_

60. Name of registrar: \_\_\_\_\_

61. Name of informant: \_\_\_\_\_

62. Name of medical officer: \_\_\_\_\_

63. Name of registrar: \_\_\_\_\_

64. Name of informant: \_\_\_\_\_

65. Name of medical officer: \_\_\_\_\_

66. Name of registrar: \_\_\_\_\_

67. Name of informant: \_\_\_\_\_

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78. Name of registrar: \_\_\_\_\_

79. Name of informant: \_\_\_\_\_

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81. Name of registrar: \_\_\_\_\_

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89. Name of medical officer: \_\_\_\_\_

90. Name of registrar: \_\_\_\_\_

91. Name of informant: \_\_\_\_\_

92. Name of medical officer: \_\_\_\_\_

93. Name of registrar: \_\_\_\_\_

94. Name of informant: \_\_\_\_\_

95. Name of medical officer: \_\_\_\_\_

96. Name of registrar: \_\_\_\_\_

97. Name of informant: \_\_\_\_\_

98. Name of medical officer: \_\_\_\_\_

99. Name of registrar: \_\_\_\_\_

100. Name of informant: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

12366

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12339

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>		d. STREET ADDRESS <b>321 Tunbridge Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alma</b> Middle <b>L.</b> Last <b>Santry</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/14/1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Otis B. Marchant</b>		14. MOTHER'S MAIDEN NAME <b>Sallie L. Shaw</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Admission records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 12 1960</b> to <b>Nov. 19 1960</b> , that (I) (we) last saw the deceased alive on <b>11/19/1960</b> , and that death occurred at <b>3:55 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert Mahon</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert Mahon, M.D.</b>		22d. ADDRESS <b>602 E. Joppa Rd. Towson, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/23/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. L. ...</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 21 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. ...</b>			

CERTIFICATE OF DEATH

1980

100-100000

100-100000

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100-100000

100-100000

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12367

## CERTIFICATE OF DEATH

Reg. Dist. No. 12340

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kingsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 1 Mt. Vista Rd.</u>				d. STREET ADDRESS <u>Rt. 1 Mt. Vista Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helen Oletta Sappington</u>				4. DATE OF DEATH Month Day Year <u>Nov. 21 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 4, 1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Thomas Todd</u>				14. MOTHER'S MAIDEN NAME <u>Anna Rebecca Stone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Thos. T. Sappington Rt. 1 Mt. Vista Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>422.1</u> DUE TO <u>Congestive Failure</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>Nov.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov. 21</u> , 19 <u>60</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>11-21-60</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland PK.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lessahn Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>NOV 23 60</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
JAN 10 1900		HOME	
AGE		SEX	
60		M	
RACE		OCCUPATION	
WHITE		FARMER	
MARRIED		SINGLE	
BORN		DIED	
JAN 10 1900		JAN 10 1900	
TIME OF DAY		PLACE OF BURIAL	
10:00 AM		HOME	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DISEASE		SYMPTOMS	
ANGINA PECTORIS		PAIN IN THE CHEST	
CORONARY ARTERY DISEASE		DYSPEPSIA	
HYPERTENSION		HEADACHE	
DIABETES		WEIGHT LOSS	
GOUT		STOMACH DISORDER	
ASTHMA		BRONCHITIS	
EMPHYSEMA		PNEUMONIA	
TUBERCULOSIS		SCURVY	
SYPHILIS		LEPROSY	
MALARIA		DYSENTERY	
CHOLERA		TYPHOID FEVER	
DIPHTHERIA		SCARLET FEVER	
MEASLES		CHICKEN POX	
SMALL POX		POLIO	
TETANUS		RABIES	
HANGING		POISONING	
SUICIDE		HOMICIDE	
UNNATURAL		NATURAL	
DISEASE		SYMPTOMS	
ANGINA PECTORIS		PAIN IN THE CHEST	
CORONARY ARTERY DISEASE		DYSPEPSIA	
HYPERTENSION		HEADACHE	
DIABETES		WEIGHT LOSS	
GOUT		STOMACH DISORDER	
ASTHMA		BRONCHITIS	
EMPHYSEMA		PNEUMONIA	
TUBERCULOSIS		SCURVY	
SYPHILIS		LEPROSY	
MALARIA		DYSENTERY	
CHOLERA		TYPHOID FEVER	
DIPHTHERIA		SCARLET FEVER	
MEASLES		CHICKEN POX	
SMALL POX		POLIO	
TETANUS		RABIES	
HANGING		POISONING	
SUICIDE		HOMICIDE	
UNNATURAL		NATURAL	



Vertical text on the right margin, likely a filing or archival note.



12368

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harbor View</b>			c. LENGTH OF STAY IN 1b <b>X Harbor View</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>501 S. 48th St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>JOHN MICHAEL SCHMIDTMAN.</b>			4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>19 60.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14, 1883</b>		9. AGE (In years last birthday) <b>77</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Co., Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Michael Schmidtman</b>			14. MOTHER'S MAIDEN NAME <b>Augusta Gransey</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>213-16-9743</b>		17. INFORMANT <b>Frederick M. Schmidtman</b> Address <b>1310 Walters Ave. Balto., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anterosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Described Anterosclerotic</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>5/15/60</b> , 19____, to <b>11/27/60</b> , 19____, that I last saw the deceased alive on <b>11/18/60</b> , 19____, and that death occurred at <b>11:30 P.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Robert J. Lyden</b>		ADDRESS (Street, city or town, state) <b>815 Eastern Ave. Balt 21, Md.</b>		DATE SIGNED <b>11/22/60</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT W. HYDIER, MD</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/30/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	
22d. LOCATION (City, town, or county) <b>5712 O'Donnell St. Balto., Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Geiler</b>		ADDRESS <b>6224 Eastern Ave. Balto., Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 30 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1918

AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1841

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

AGE AT DEATH

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

AGE AT DEATH

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CAUSE OF DEATH

AGE AT DEATH

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12369

Item 4 Film 0276 12-6-60 at

12342

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rockdale) Balto. 7</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3433 Liberty Garden Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rockdale) Balto. 7</b>	
3. NAME OF DECEASED (Type or print) First <b>Betty</b> Middle <b>Jane</b> Last <b>Schubert</b>		4. DATE OF DEATH Month <b>11</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1943</b>
9. AGE (In years lost birthday) <b>17</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert J. Schubert</b>		14. MOTHER'S MAIDEN NAME <b>Lillian V. Sanford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Albert J. Schubert</b>		Address <b>Balto. 7 3433 Liberty Garden Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral acute lobar pneumonia</b> DUE TO <b>Hydrocephalus - post meningitis -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>age 5 mos. recurrent attacks pneumonia</b> DUE TO <b>age 5 mos. recurrent attacks pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>344x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>17 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 1950</b> to <b>Nov. 13, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 13, 1960</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas E. Wheeler</b>		22b. DATE SIGNED <b>11-13-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas E. Wheeler</b>		22d. ADDRESS <b>3601 Clifmar Road, Balto. 7, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 16, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Spring Byers</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Krame</b>	
ADDRESS <b>8728 Liberty Road</b>		DATE <b>NOV 18 '60</b>	
<b>Randallstown, Md.</b>			

4452

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12370

**CERTIFICATE OF DEATH**

12344

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b>				c. LENGTH OF STAY IN 1b <b>78 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>211 Forest Spring Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>RODGER G. SCHULL</b>		4. DATE OF DEATH <b>November 8 1960</b>		5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville - 28</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 12, 1925</b>	9. AGE (In years last birthday) <b>34</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sheet Metal</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George G. Schull</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte E. Frizzel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-20-7639</b>		17. INFORMANT <b>Clinical Records</b> <b>VAH, Baltimore 18, Maryland, FORT HOWARD DIVISION</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4344</b> IMMEDIATE CAUSE (a) <b>EDEMA OF THE LUNGS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARDIAC DILATATION AND MODERATE HYPERTROPHY</b> (c) <b>NEURODERMATITIS</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 HOURS +</b> <b>UNKNOWN</b> <b>6 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 22, 1960</b> to <b>November 8, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 8, 1960</b> , and that death occurred at <b>1:10 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Frederick S. Donaldson</i> 22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>				22b. DATE <b>11/8/60</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
22d. ADDRESS <b>VAH, BALTIMORE 18 MD. FORT HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-11-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>U.S. National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick &amp; Wade</i> ADDRESS <b>Frederick &amp; Wade Ave; 28</b>				25a. REC'D BY REGISTRAR <b>NOV 14 1960</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12300

CERTIFICATE OF DEATH

12310

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12343

12371

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ft. Howard Veterans Admin. Hospital</b>				d. STREET ADDRESS <b>215 Westowne Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>PAUL</b> Last <b>SEBRA</b>				4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 27, 1903</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>52</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Advertising</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Sebra</b>				14. MOTHER'S MAIDEN NAME <b>Anna Sebra</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War II</b>		17. INFORMANT <b>Mrs. Erma W. Sebra-215 Westowne Road #29</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>A-S-C-V-Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>A-S-C-V-Disease</b> DUE TO (c) <b>A-S-C-V-Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>420-1</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M.B. Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M.B. DAVIS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Robinson Sons</b>				24a. REC'D BY REGISTRAR <b>DATE NOV 28 1960</b>		24b. REGISTRAR'S SIGNATURE <b>James L. Thomas</b>	

MEDICAL CERTIFICATION

TO DEED: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

15251

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12345

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Danville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Danville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Danville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE STAFFORD SETTLES</u>		4. DATE OF DEATH <u>Nov 4 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	9. AGE (In years last birthday) <u>66</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Front Royal, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-01-9433</u>	
17. INFORMANT <u>Mrs H. Hite - 5907 Carroll St - Baltimore, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic C-V. Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>none</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>none</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Nov 4 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-7-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>	22d. LOCATION (City, town, or country) (State) <u>Ellicott City Md</u>
23. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md</u>		24a. REC'D BY REGISTRAR <u>NOV 7 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1982

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1982-10-10

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1982-10-10

1982-10-10

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12346

12373

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b> c. LENGTH OF STAY IN lb <b>56 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3619 S. Hanover Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM J. B. SHANNON</b>			4. DATE OF DEATH Month Day Year <b>November 10 1960</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>February 19, 1897</b>		9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elect;ric</b>		11. BIRTHPLACE (State or foreign country) <b>Marion, Virvinia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>William H. Shannon</b>				
14. MOTHER'S MAIDEN NAME <b>Mary E. Spratt</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				
16. SOCIAL SECURITY NO. <b>WW I 241-05-8962</b>		17. INFORMANT Address <b>Clin.Rec.,VAH, Baltimore 18,Md.FORT HOWARD DIV.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED PERITONITIS</b> DUE TO <b>PERFORATION OF STOMACH AND TRANSVERSE COLON AT THE SITES OF SURGERY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>ADENOCARCINOMA OF THETRANSVERSE COLON WITH PERFORATION INTO THE STOMACH</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNKNOWN</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>2 weeks</b> <b>UNKNOWN</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Baltimore</b>		20g. (County) <b>Anne Arundel</b>		20h. (State) <b>Maryland</b>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 15, 1960</b> to <b>November 10, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 10, 1960</b> , and that death occurred at <b>2:00</b> A. M., from the causes and on the date stated above.							
22a. SIGNATURE <b>FREDERICK S. DONALDSON</b>		22b. DATE <b>11/10/60</b>		22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>			
22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>			
23d. LOCATION (City, town, or county) <b>Anne Arundel County</b>		23e. (State) <b>Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner</b>		ADDRESS <b>North and Penna. Avenues, XX</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1960</b>			
25b. REGISTRAR'S SIGNATURE <b>C. S. Thoma</b>		25c. DATE <b>Baltimore, Md.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



2



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12217**  
**CERTIFICATE OF DEATH**

12347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Reisterstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Falls Road</b>				d. STREET ADDRESS <b>Glenn Falls Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Oliver</b>		First <b>A.</b> Middle <b>Shipley</b>		Last <b>Shipley</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>24,</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 16, 1883</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired from State Roads</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>				13. FATHER'S NAME <b>John L. Shipley</b>			
14. MOTHER'S MAIDEN NAME <b>Mannie Cook</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				INFORMANT Address <b>Mrs. Clara D.V. Shipley Reisterstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> years DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 21, 1960</b> to <b>November 24, 1960</b> that I last saw the deceased alive on <b>Nov. 24, 1960</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Martin E. Strobel</b>		M.D. <b>48 Main Street</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>11-25-60</b>	
PHYSICIAN'S NAME (Type) <b>Martin E. Strobel M.D.</b>		Reisterstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 28, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons Reisterstown, Md.</b>				ADDRESS <b>Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 29 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				DATE			

Page 4  
The law requires that the death certificate be executed within 24 hours after death.  
The attending physician and completely filled in by the funeral director.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 48 hours after death.



# 1 12374 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18 Items 9, 14 Film 6275 11-23-60 et CERTIFICATE OF DEATH 12348 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Rose Dale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Rose Dale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7911 Shirley Ave.</b>		d. STREET ADDRESS <b>17911 Shirley Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>L.</b> Last <b>SKINNER</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1885</b>
9. AGE (In years last birthday) <b>75 1/4 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>FRANK A. Schwalenberg</b>	
14. MOTHER'S MAIDEN NAME <b>Helen (Last name unknown)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>215-09-7915D</b>		17. INFORMANT <b>Frank A. Skinner 7911 Shirley Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>155. Staudstill of the heart</b> DUE TO <b>Carcinoma of the gall bladder with metastases (operated on 8/17/60)</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While Not while at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/13</b> , 19 <b>60</b> , to <b>her death</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2 wks ago</b> , 19 <b>60</b> , and that death occurred at <b>8:00 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. J. Geldrich</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 16, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Com. Baltimore, Md</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip E. Coach 1211 Chesaco Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 17 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1887

THE

THE

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12375

CERTIFICATE OF DEATH

12349

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>Baltimore 11</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3801-4</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 11</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1134 Halstead Road</b>		d. STREET ADDRESS <b>410 W. 28th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET R. SMITH</b> Middle <b></b> Last <b></b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1892</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b></b>	
13. FATHER'S NAME <b>John Dolch</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-40-3001</b>	
17. INFORMANT <b>Mrs. Irma Stambaugh-751 Cator Avenue #18</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>Calcific Nephroses</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Osteitis Deformans (Paget's Disease of Bone)</b> DUE TO <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>years</b> <b>20 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1960</b> to <b>15 Nov, 1960</b> , that (I) (we) last saw the deceased alive on <b>15 Nov 1960</b> and that death occurred at <b>1:13 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frederick H. Keown M.D.</b>		22b. DATE SIGNED <b></b>	
22c. PHYSICIAN'S NAME (Type) <b></b>		22d. ADDRESS <b>1938 Linden Ave Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/19/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner Sons</b>		25a. REC'D BY REGISTRAR <b>NOV 18 '60</b>	
ADDRESS <b>Baltimore - 17, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Lickner</b>	

1938

CERTIFICATE OF DEATH

1938

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bare Hills, Baltimore 9</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bare Hills, Baltimore 9</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>6211 Falls Road</b>		d. STREET ADDRESS <b>6211 Falls Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Mrs. Mary</b> Middle <b>B.</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 13, 1874</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Ward Donaldson</b>		14. MOTHER'S MAIDEN NAME <b>Kesander -----</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Harry W. Smith</b>		Address <b>Brooklandville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>✓</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>✓</b> Day <b>19</b> Year <b>19</b> Hour a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-</b> , 19 <b>60</b> , to <b>11-29-60</b> , that I last saw the deceased alive on <b>11-27-60</b> , and that death occurred at <b>12 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. Saffell</b>		DATE SIGNED <b>11-29-60</b>	
PHYSICIAN'S NAME (Type) <b>James E. Saffell</b>		ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 2, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DEC 1 '60</b>	
ADDRESS <b>3631 Falls Road Baltimore II</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12351

12377

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE CO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM</b>		c. LENGTH OF STAY IN 1b <b>TIMONIUM</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>YORK ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MIRIAM</b> Middle <b>F.</b> Last <b>SNYDER</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>10</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 8, 1891</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM E. SNYDER FELDMAYER</b>		14. MOTHER'S MAIDEN NAME <b>HANNA E. NINGARD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>FAMILY RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO <b>Sudden</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio Renal</b> DUE TO <b>Vascular Disease</b> (c) <b>10/9/55</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10/9/55</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 19 1960</b> to <b>November 9 1960</b> that (I) (we) last saw the deceased alive on <b>November 9 1960</b> and that death occurred at <b>11 P. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles F. O'Donnell</b>		22b. DATE SIGNED <b>11/14/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b>		22d. ADDRESS <b>17501 York Rd - #4md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/15/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>CATONSVILLE MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons</b>		25. REC'D BY REGISTRAR <b>NOV 17 '60</b>	
ADDRESS <b>Towson Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

1891

CERTIFICATE OF DEATH

12345

10



DECEASED  
NAME  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
CAUSE OF DEATH  
DATE OF DEATH  
PLACE OF DEATH  
SIGNATURE OF DECEASED  
SIGNATURE OF WITNESSES  
SIGNATURE OF MINISTER OF THE GOSPEL  
SIGNATURE OF REGISTRAR  
SIGNATURE OF MEDICAL OFFICER

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12352

12378 Item 23b, File 0274 11/17/60 ink

**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balto</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>59 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>			d. STREET ADDRESS <b>320 TOWNSEND ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <b>ALBERT J. SPANGLER</b>			<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>6</b> Year <b>19 60</b>		
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>January 17, 1907</b>		<b>9. AGE</b> (In years lost birthday) <b>53</b> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HALLDEN MACHINE OPERATOR</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>COPPER &amp; BRASS CO</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>WILLIAM SPANGLER</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>KATHERINE REITER</b>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW-11</b>		<b>16. SOCIAL SECURITY NO.</b> <b>WW-11</b>		<b>17. INFORMANT</b> <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>MESENTERIC THROMBOSIS</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>36 HOURS</b>  <b>10 DAYS</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>PULMONARY EMPHYSEMA; ASTHMA; RHEUMATOID ARTHRITIS; LEFT VENTRICULAR HYPERTROPHY</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19____		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> _____ (County) _____ (State) _____					
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 8, 1960</b> to <b>November 6, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 6, 1960</b> , and that death occurred at <b>9:10 A.M.</b> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> 			<b>22b. DATE SIGNED</b> <b>11-6-60</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>ERNEST O. BROWN</b>			<b>22d. ADDRESS</b> <b>M.D. VAH BALTIMORE 18 MD - Ft Howard Div</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11/10/1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>OAK HILL CEMETERY</b>	
<b>23d. LOCATION</b> (City, town, or county) <b>BALTIMORE, MARYLAND</b> (State) _____					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J.G. Connelly &amp; Sons</b>			<b>25a. REC'D BY REGISTRAR</b> <b>NOV 9 '60</b>		
<b>25b. REGISTRAR'S SIGNATURE</b> 					

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.







**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12353

12379

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>V. A. Hospital</b>				d. STREET ADDRESS <b>135 West Street</b>			
3. NAME OF DECEASED (Type or print) First <b>STEPHEN</b> Middle <b>T.</b> Last <b>SPRIGGS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1892</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>West River, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Kent Spriggs</b>				14. MOTHER'S MAIDEN NAME <b>Clara MN: Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-1 213-16-6633</b>		17. INFORMANT <b>Clinical Records</b> Address <b>VAH Baltimore, Md.-Fort Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>CANCER OF ESOPHAGUS</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>  <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 18</b> 19 <b>60</b> to <b>Nov. 20</b> 19 <b>60</b> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>Nov. 20</b> , 19 <b>60</b> , and that death occurred at <b>A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Jerome D. Gorman</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JEROME D. GORMAN, M.D.</b>				22d. ADDRESS <b>VAH, Baltimore, Md. Ft. Howard Div.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-23-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese</b>				ADDRESS <b>W. Washington Street Annapolis, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 21 '60</b> DATE	
				25b. REGISTRAR'S SIGNATURE <i>Curtis S. Thomas</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

15830

EXTRACT OF BIRTH



1

CHIEF

30-02-11

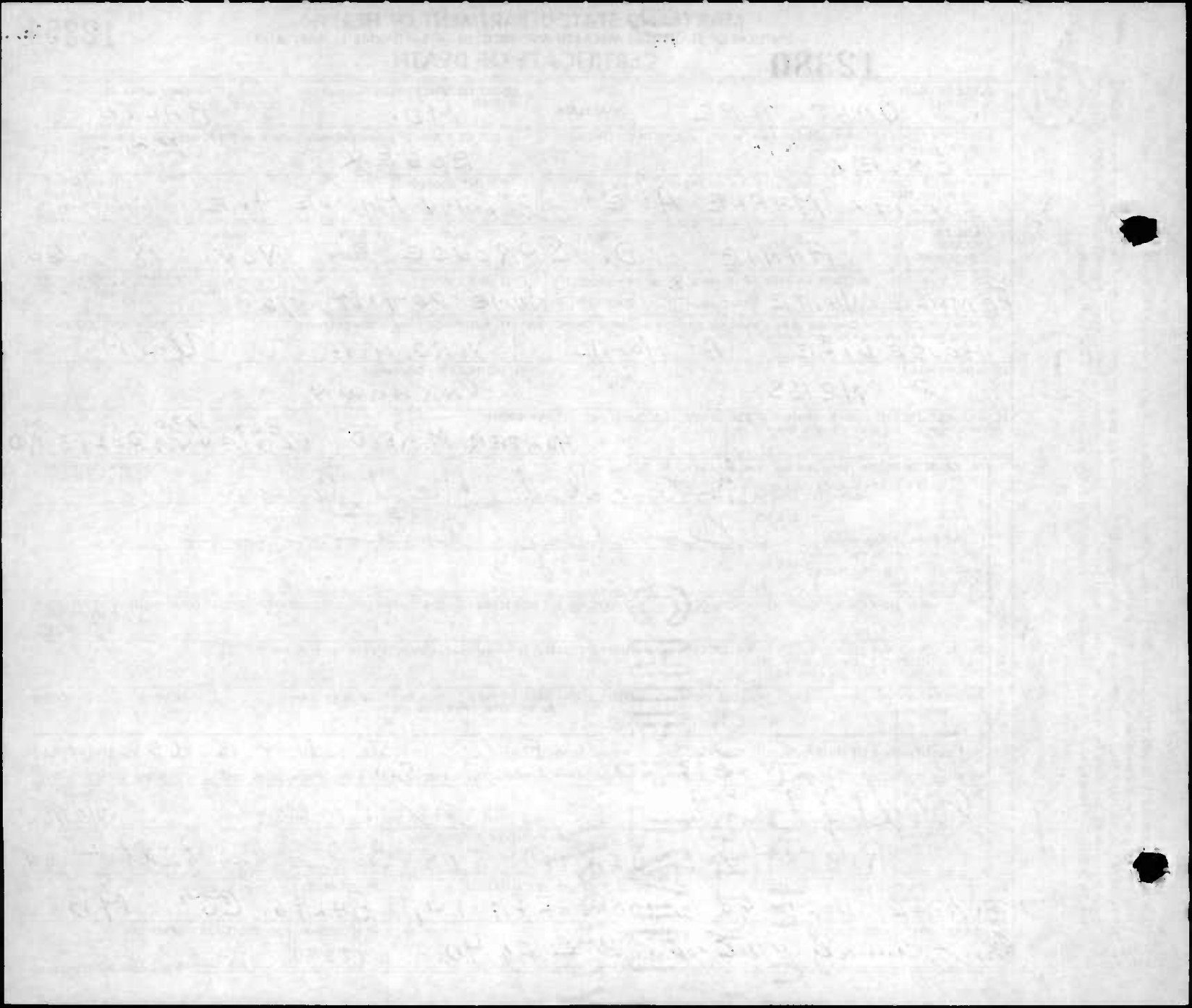
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12354

12380

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box-194 MAPLE AVE</b>				d. STREET ADDRESS <b>Box-194 MAPLE AVE 1</b>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>D.</b> Last <b>SPROUSE</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 20-1884</b>		9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>P. WEISS</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HUNTER M. REID</b> Address <b>Box 430 OLD ANNAPOLIS RD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> 1956 to <b>Nov 18, 1960</b> that (I) (we) last saw the deceased alive on <b>Nov 17 1960</b> and that death occurred at <b>5AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert J. Lyden</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/21/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT J. LYDEN, M.D.</b>				22d. ADDRESS <b>815 Eastern Ave Balt 21, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-21-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>		23d. LOCATION (City, town, or county) (State) <b>BALTO. CO MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John S. Connelly</b>				ADDRESS <b>418 Eastern Blvd 21, MD</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 22 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Brown</b>			



12206  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk (22)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>99 Dundalk Avenue</b>		d. STREET ADDRESS <b>99 Dundalk Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHLOE</b> Middle <b>+++++</b> Last <b>SQUIRES</b>		4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1876</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>George Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Martha Miley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>C.F. Fisher, Route 2, Jane Lew, W. Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>malnutrition</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Month</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 27</b> , 19 <b>60</b> to <b>Nov 11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11 Nov 60</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3 Kinship Road</b> DATE SIGNED <b>11/14/60</b>			
ACTUAL SIGNATURE <b>W. Morrison</b>		M.D. <b>3 Kinship Road</b>	
PHYSICIAN'S NAME (Type) <b>W. Herbert Morrison, M.D.</b>		<b>Baltimore 22, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/15/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>		24a. REC'D BY REGISTRAR <b>NOV 16 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







CERTIFICATE OF DEATH

Reg. Dist. No.

12356

12381

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>12yr6mth25dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. STREET ADDRESS <u>Unknown</u>			
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Stinefelt</u> Last <u>Stinefelt</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>19 60</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 4, 1873</u>	
9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>dressmaking</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Bernard Stinefelt</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Strecker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis, severe</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov. 15</u> , 19 <u>60</u> , to <u>Nov. 20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov. 20</u> , 19 <u>60</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>			
DATE SIGNED <u>11-21-60</u>				M.D. <u>Stella Wachslar, M. D.</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				ADDRESS <u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov 23, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY W. JENKINS &amp; SONS Co</u>				ADDRESS <u>4905 YORK RD</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 21 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Tread</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

12357

12382

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7803 Clarksworth Place</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Anna (Ida Louise) Stolle</i>		4. DATE OF DEATH Month Day Year <i>November 16, 1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 17, 1886</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Germany</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>August Schwarzklose</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>215-09-9646B</i>		17. INFORMANT Address <i>Mrs. Else Schwarzkopf same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> <i>199-2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov 15, 1960</i> , to <i>Nov 16, 1960</i> , that I last saw the deceased alive on <i>Nov 15, 1960</i> , and that death occurred at <i>1:30 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>7122 Harford Rd Baltimore 11/17/60</i>			
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. <i>[Signature]</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/19/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 18 '60</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
12383				CERTIFICATE OF DEATH			12358			
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. LENGTH OF STAY IN lb <b>2 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8503 Harford Road</b>					d. STREET ADDRESS <b>8503 Harford Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>L.</b> Last <b>STRASSHEIM</b>					4. DATE OF DEATH Month <b>November</b> Day <b>29</b> , Year <b>1960</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 28, 1891</b>		9. AGE (In years last birthday) yrs. <b>69</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Emmart</b>					14. MOTHER'S MAIDEN NAME <b>Ella May Henry</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>214-03-1347A</b>		INFORMANT Address <b>Mr. Frederick Strassheim</b> <b>3715 Lyndale Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>14 yrs</b> <b>15 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>July</b> , 19 <b>60</b> , to <b>November</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>November 29, 1960</b> , and that death occurred at <b>8:45 AM</b> ; from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>8503 Harford Rd., Balto., Md. 11/29/60</b>										
ACTUAL SIGNATURE <b>Frederick Strassheim</b>					M.D. <b>8503 Harford Rd., Balto., Md. 11/29/60</b>					
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/2/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC. Balto., Md.</b>					ADDRESS <b>BALTO. 14</b>		24a. REC'D BY REGISTRAR <b>DEC 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

\*BASED ON THE FOLLOWING ASSUMPTIONS:



12384

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELLEN JOSEPHINE (NELLIE) STREB</b>		4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1887</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Minnick</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth J. Rowe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Louise Bonsall</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 11, 1959</b> , to <b>Nov 12, 1960</b> , that I last saw the deceased alive on <b>Nov 12, 1960</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George A. Knipp</b>		ADDRESS (Street, city or town, state) <b>4116 Edmondson Ave. Balto., 29, Md</b>	
PHYSICIAN'S NAME (Type) <b>George A. Knipp M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/17/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		24a. REC'D BY REGISTRAR <b>NOV 16 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

FOR STATE  
HEALTH DEPT.

TO DEP  
EXEC  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>6</u> <del>Year</del> Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>717 N. Avondale Rd.</u>				d. STREET ADDRESS <u>717 N. Avondale Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Catherine Lash Stroud</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1902</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Danville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Douglas</u>				14. MOTHER'S MAIDEN NAME <u>Mildred ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>242-09-0256</u>		17. INFORMANT Address <u>Mrs. Emma Bratcher-122 Willow Ct.-22</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Left Breast</u> DUE TO (b) <u>@ Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Terminal Hypostatic Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 mos</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Law</u>				24a. REC'D BY REGISTRAR <u>NOV 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

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(M)

(I)

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ISSUED MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

NAME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF DEPARTURE FROM STATE

DATE OF RETURN TO STATE

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
12385 CERTIFICATE OF DEATH 12361									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> d. STREET ADDRESS <b>3801 Dovedale Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>STANLEY</b> Middle <b>J.</b> Last <b>STRYCHARZ</b>					4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1960</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 2, 1909</b>		9. AGE (In years last birthday) <b>51</b> yrs. IF UNDER 1 YEAR: Months <b>51</b> Days <b>17</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glazier</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Glazing</b>			11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Strycharz</b>					14. MOTHER'S MAIDEN NAME <b>Katherine Feelor</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>					16. SOCIAL SECURITY NO. <b>720-10-5120</b>		17. INFORMANT <b>Clinical Records</b> <b>VAH, Balto. 18, Md., Fort Howard Division</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA RIGHT LUNG</b> <b>581.0</b> DUE TO Conditions, if only, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>PORTAL CIRRHOSIS OF THE LIVER</b> DUE TO (c) <b>2 years</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 8, 1960</b> to <b>November 17, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 17, 1960</b> , and that death occurred at <b>10:10A</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Frederick S. Donaldson</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/18/60</b>		
22c. PHYSICIAN'S NAME (Type) <b>Frederick S. Donaldson, M.D.</b>					22d. ADDRESS <b>VAH, Balto 18, Md., Ft Howard Division</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Nov. 21, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b> ADDRESS <b>Home Reisterstown Road and Waldron Aves, Pikesville, Md.</b>					25a. REC'D BY REGISTRAR <b>NOV 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>		

1938

CERTIFICATE OF DEATH

1938

Form with multiple lines for text entry, including fields for name, date, and location. The text is mirrored and appears to be bleed-through from the reverse side of the page.



TO DEED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>53</b> Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3418 Dunhaven Road</b>		d. STREET ADDRESS <b>3418 Dunhaven Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LAURA B. STUBER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1882</b>
9. AGE (In years, months, days) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>18</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles E. Teeters</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Gallagher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Maude Fahey</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A-S-C-V DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Melvin B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>11/25/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-29-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ridge Road Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Gary, Indiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Balto., 22</b>		ADDRESS <b>Walter Brooks Bradley, Inc., Balto., 22</b>	
24a. REC'D BY REGISTRAR <b>NOV 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Foran</b>	

12208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Occupation		8. Cause of Death		9. Manner of Death		10. Signature of Examiner	
11. Signature of Physician		12. Signature of Coroner		13. Signature of Medical Examiner		14. Signature of Registrar		15. Signature of Clerk	
16. Signature of Nurse		17. Signature of Chaplain		18. Signature of Minister		19. Signature of Priest		20. Signature of Rabbi	
21. Signature of Imam		22. Signature of Other		23. Signature of Other		24. Signature of Other		25. Signature of Other	
26. Signature of Other		27. Signature of Other		28. Signature of Other		29. Signature of Other		30. Signature of Other	
31. Signature of Other		32. Signature of Other		33. Signature of Other		34. Signature of Other		35. Signature of Other	
36. Signature of Other		37. Signature of Other		38. Signature of Other		39. Signature of Other		40. Signature of Other	
41. Signature of Other		42. Signature of Other		43. Signature of Other		44. Signature of Other		45. Signature of Other	
46. Signature of Other		47. Signature of Other		48. Signature of Other		49. Signature of Other		50. Signature of Other	
51. Signature of Other		52. Signature of Other		53. Signature of Other		54. Signature of Other		55. Signature of Other	
56. Signature of Other		57. Signature of Other		58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other		64. Signature of Other		65. Signature of Other	
66. Signature of Other		67. Signature of Other		68. Signature of Other		69. Signature of Other		70. Signature of Other	
71. Signature of Other		72. Signature of Other		73. Signature of Other		74. Signature of Other		75. Signature of Other	
76. Signature of Other		77. Signature of Other		78. Signature of Other		79. Signature of Other		80. Signature of Other	
81. Signature of Other		82. Signature of Other		83. Signature of Other		84. Signature of Other		85. Signature of Other	
86. Signature of Other		87. Signature of Other		88. Signature of Other		89. Signature of Other		90. Signature of Other	
91. Signature of Other		92. Signature of Other		93. Signature of Other		94. Signature of Other		95. Signature of Other	
96. Signature of Other		97. Signature of Other		98. Signature of Other		99. Signature of Other		100. Signature of Other	

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RECORDS AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

14591

5/17/61 14595

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float:right">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) <span style="float:right">✓</span> a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>24yr9mth25dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Sullivan</u>		4. DATE OF DEATH Month Day Year <u>November 25 19 60</u>	
5. SEX <u>white</u>	6. COLOR OR RACE <u>female</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March, 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Smith</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ella Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address _____	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u>			INTERVAL BETWEEN ONSET AND DEATH _____
DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u>			_____
DUE TO (c) _____			_____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1958</u> to <u>Nov. 25, 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov. 25, 1960</u> , and that death occurred at <u>8:35</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachslar</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>4-4-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sent to</u>		23b. DATE THEREOF <u>4/11/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of M. Medical School</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Medical Board</u>		ADDRESS _____	
25a. REC'D BY REGISTRAR DATE <u>APR 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

MEDICAL CERTIFICATION

1892

History of the Medical School

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12386

## CERTIFICATE OF DEATH

Reg. Dist. No.

12363

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Wilmington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Joseph's Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>PETER SZCZECINSKI (PIOTR SZCZECINSKI)</b>				4. DATE OF DEATH <b>November 23, 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 29, 1879</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Iron Foundry</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph Szczecinski</b>				14. MOTHER'S MAIDEN NAME <b>Maryanna Dziobak</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>221-10-4438</b>		17. INFORMANT <b>St. Joseph's Nursing Home, Tugwell Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>422.01</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO (c) <b>Senile Changes</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>15+ yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12/12, 1959</b> , to <b>11/23, 19 60</b> , that I last saw the deceased alive on <b>11/23, 19 60</b> , and that death occurred at <b>8:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Victor F. King</b>				ADDRESS (Street, city or town, state) <b>1102 E. Joppa Road, Towson</b>			
DATE SIGNED <b>11/25</b>							
PHYSICIAN'S NAME (Type) <b>Victor F. King</b>				1102 E. Joppa Road, Towson			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/26/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. F. SADOWSKI &amp; SONS, 1808 EASTERN AVENUE</b>				24a. REC'D BY REGISTRAR <b>28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. King</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12387 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12364

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPARROWS POINT</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>2844 W. Lanvale St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>IRA TAYLOR</b>		First		Middle		Last		4. DATE OF DEATH <b>November 17, 1960</b>		Month		Day		Year					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1895</b>		9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>		11. BIRTHPLACE (State or foreign country) <b>Lagrange N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>		13. FATHER'S NAME <b>Edward Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Hester</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mary J. Taylor 2844 W. Lanvale St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured myocardial infarction.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>November 17, 1960</b>											
ACTUAL SIGNATURE <b>W. V. Lovitt</b>		EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/21/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		22e. (State) <b>Md.</b>		23. FUNERAL DIRECTOR <b>Mrs. Kate R. Williams Schroeder</b>		24a. REC'D BY REGISTRAR <b>NOV 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

THE CHAIR  
STATE OF

18187

ATTEST: MEDICAL EXAMINER CERTIFICATE OF DEATH

Deceased

Residence

Signature

Signature

DATE: NOV. 1, 1900

NOV. 1, 1900

DATE

DATE

1

Death and Burial Information

NOVEMBER 1, 1900

DATE: NOV. 1, 1900

WHS: CH

**1**  
**FOR STATE**  
**HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**12388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**12365**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Essex #21</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Essex #21</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>205 "A" Woodvale Rd.</b>				d. STREET ADDRESS <b>1 205 "A" Woodvale Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM THOMAS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1900</b>	9. AGE (In years last birthday) yrs. <b>60</b>	IF UNDER 1 YEAR Months <b>60</b> Days <b>17</b> Hours <b>19</b> Min. <b>60</b>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Apt. Buildings</b>		11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>004-12-7660</b>		17. INFORMANT <b>Harold Wall 2218 Lodge Farm Rd. #19</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>DATE SIGNED 11-17-60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/21/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR <b>James E. Brundzinski</b> ADDRESS <b>3021 Eastern Ave</b>				24a. REC'D BY REGISTRAR <b>NOV 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND REPORTS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
1918

FOR FILE  
IN THE  
DEPT. OF HEALTH

1

*[Faint, mostly illegible text, likely a medical certificate or report, possibly containing a signature.]*

VS. A15ME  
5M 7/S9)

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH



100

1288 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH BOARD

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF EXAMINER  
DATE OF EXAMINATION

RESIDENT OF  
CITY OF  
COUNTY OF  
STATE OF

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
12390  
12367  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>3 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3. NAME OF DECEASED (Type or print) First <b>Leonora</b> Middle <b>Thornberg</b> Last <b>Thornberg</b>			
4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1960</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9/4/1879</b>		9. AGE (In years lost birthday) yrs. <b>81</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hwf.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>James Montgomery</b>			
14. MOTHER'S MAIDEN NAME <b>Kate Maude Kitzell</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Admission records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO (b) <b>Primary Site Not Determined</b> DUE TO (c) <b>Primary Site Not Determined</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug.</b> 19 <b>60</b> to <b>Nov.</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Nov. 2</b> 1960, and that death occurred at <b>5:04 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>R. J. Mahon</b>				22b. DATE SIGNED <b>Nov. 2 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. J. MAHON M.D.</b>				22d. ADDRESS <b>602 E. Joppa Rd, Towson 4 MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 8, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook- Towson</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 7 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

CERTIFICATE OF DEATH

18198

1

CHESTER

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 7/59

BIO

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12391 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12368													
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riderwood</b>						c. LENGTH OF STAY IN b <b>4</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1409 Walnut Avenue</b>						d. STREET ADDRESS <b>1409 Walnut Avenue</b>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>HENRY</b> Last <b>TILLMAN</b>						4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>60</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 12, 1884</b>		9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Electrical Engineer - Balto. Gas Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>North Carolina</b>							
13. FATHER'S NAME <b>David Childs Tillman</b>						14. MOTHER'S MAIDEN NAME <b>Martha Ledbetter</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>212-05-6710</b>		17. INFORMANT <b>Mr. Richard M. Tillman-3035 St. Paul Street</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemopericardium</b> DUE TO (b) <b>Traumatic rupture of aorta</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>978x</b>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Apparently jumped out of window</b>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11/10/60</b> <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Baltimore</b>		(County) (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>11/10/60</b>					
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>11/13/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>				22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>					
23. FUNERAL DIRECTOR <b>Wm. J. Ticken</b>						ADDRESS <b>Balto - 17, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 14 '60</b>		24b. REGISTRAR'S SIGNATURE <b>James S. Kraus</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12392  
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

12369

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>7 1/2 yrs</b>		d. STREET ADDRESS <b>1803 W. BALTIMORE ST.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Toennies</b>		4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1873</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>M.D.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Bartels</b>		14. MOTHER'S MAIDEN NAME <b>Hollwig</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Charles S. Toennies - 1803 W. Balt. St.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10/11/60</b> <b>1953</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Skin Ulcerations &amp; Decubiti</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1958</b>		20f. (City or town) <b>11/14/60</b> (County) (State)	
21. I certify that I attended the deceased from <b>11/12/60</b> to <b>11/14/60</b> , that I last saw the deceased alive on <b>11/12/60</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. E. McGretz</b> M.D.		ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 2nd</b> DATE SIGNED <b>11/14/60</b>	
PHYSICIAN'S NAME (Type) <b>W. E. McGretz</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-17-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park Cmn.</b>	22d. LOCATION (City, town, or county) (State) <b>Balls Blk. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Foley-Covernough F. H.</b> ADDRESS <b>Catonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 18 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Charles S. Toennies</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12393 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

12370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Tollgate Rd, Owings Mills, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Agnes</u> Last <u>Traylor</u>				4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25, 1905</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.		IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert C. Dudley</u>				14. MOTHER'S MAIDEN NAME <u>Bridgeth Caffrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>				16. SOCIAL SECURITY NO. <u>220-22-6540</u>			
17. INFORMANT <u>Spouse</u> Address <u>#15 Tollgate Rd Owings Mills, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma</u> DUE TO <u>199.2</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> DUE TO <u>3 days</u>							
(c) <u>3 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 25, 1905</u> to <u>Nov 3, 1960</u> , that I lost the deceased alive on <u>11-4-60</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Martin J. Feldman</u> M.D. <u>#1 Cherry Hill Rd</u>							
PHYSICIAN'S NAME (Type) <u>Martin J. Feldman</u> <u>Reisterstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Nov 7, 1960</u>		<u>New Cathedral Cemetery</u>		<u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u> Address <u>Pikesville, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 9 '60</u>			
				24b. REGISTRAR'S SIGNATURE <u>John S. Frank</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12371

12394

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b>		c. LENGTH OF STAY IN 1b <b>23 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>323 East University Parkway</b>					
3. NAME OF DECEASED (Type or print) First <b>MILTON</b>		Middle <b>P.</b>		Last <b>TRAPPE</b>		4. DATE OF DEATH Month <b>November</b>		Day <b>23</b>	
Year <b>19 60</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 27, 1891</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>69</b>		IF UNDER 24 HRS. Days <b>69</b>		Hours <b>69</b>		Min. <b>69</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Freight Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>August F. Trappe</b>		14. MOTHER'S MAIDEN NAME <b>Anna M E. Pruess</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 717-07-8283</b>		17. INFORMANT <b>Clinical Records</b>		Address <b>VAH, Baltimore 18, Maryland, FT. HOWARD DIVISION</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PORTAL CIRRHOSIS OF LIVER</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 31</b> 19 <b>60</b> to <b>Nov. 23</b> 19 <b>60</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 23</b> 19 <b>60</b> , and that death occurred at <b>6:25 A</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>John D. Talbert MD</b>		22b. DATE SIGNED <b>11/23/60</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18 MD. FORT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/28/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) <b>Baltimore</b>		23e. REGISTRAR'S SIGNATURE <b>Charles L. Haines</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Tickner &amp; Sons, Inc. North &amp; Penna. Aves.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 28 60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Haines</b>					

2051

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12372

12395

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Roseale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Roseale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1410 Rosewick Ave.</u>				d. STREET ADDRESS <u>1410 ROSEWICK AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>V.</u> Last <u>VLK</u>			4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>22</u> Year <u>1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-13</u>		9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Vincent VLK</u>				14. MOTHER'S MAIDEN NAME <u>Hughes Samec</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-01-4412</u>		17. INFORMANT <u>Hilda G. VLK</u> Address <u>1410 Rosewick Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE WITH PREVIOUS</u> DUE TO (c) <u>MYOCARDIAL INFARCTION</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB 11</u> , 19 <u>60</u> , to <u>NOV 22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>NOV 22</u> , 19 <u>60</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John G. Orth, M.D.</u>			ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd.</u>			DATE SIGNED <u>11-22-60</u>	
PHYSICIAN'S NAME (Type) <u>John G. Orth, M.D.</u>			ADDRESS <u>8019 Philadelphia Rd.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-26-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mountland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Crach</u> ADDRESS <u>1211 Chesaco Ave.</u>				24a. REC'D BY REGISTRAR <u>NOV 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. K...</u>	



CERTIFICATE OF DEATH

12345

1. NAME OF DECEASED JAMES H. SMITH		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1890		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. DATE OF DEATH 1955		9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease	
11. SIGNATURE OF DECEASED (Blank)		12. SIGNATURE OF WITNESS (Blank)		13. SIGNATURE OF PHYSICIAN (Blank)		14. SIGNATURE OF CORONER (Blank)		15. SIGNATURE OF REGISTRAR (Blank)	
16. NAME OF PHYSICIAN Dr. J. H. Smith		17. NAME OF CORONER John Doe		18. NAME OF REGISTRAR Jane Doe		19. NAME OF WITNESS John Doe		20. NAME OF PHYSICIAN Dr. J. H. Smith	
21. NAME OF CORONER John Doe		22. NAME OF REGISTRAR Jane Doe		23. NAME OF WITNESS John Doe		24. NAME OF PHYSICIAN Dr. J. H. Smith		25. NAME OF CORONER John Doe	
26. NAME OF REGISTRAR Jane Doe		27. NAME OF WITNESS John Doe		28. NAME OF PHYSICIAN Dr. J. H. Smith		29. NAME OF CORONER John Doe		30. NAME OF REGISTRAR Jane Doe	
31. NAME OF WITNESS John Doe		32. NAME OF PHYSICIAN Dr. J. H. Smith		33. NAME OF CORONER John Doe		34. NAME OF REGISTRAR Jane Doe		35. NAME OF WITNESS John Doe	
36. NAME OF PHYSICIAN Dr. J. H. Smith		37. NAME OF CORONER John Doe		38. NAME OF REGISTRAR Jane Doe		39. NAME OF WITNESS John Doe		40. NAME OF PHYSICIAN Dr. J. H. Smith	
41. NAME OF CORONER John Doe		42. NAME OF REGISTRAR Jane Doe		43. NAME OF WITNESS John Doe		44. NAME OF PHYSICIAN Dr. J. H. Smith		45. NAME OF CORONER John Doe	
46. NAME OF REGISTRAR Jane Doe		47. NAME OF WITNESS John Doe		48. NAME OF PHYSICIAN Dr. J. H. Smith		49. NAME OF CORONER John Doe		50. NAME OF REGISTRAR Jane Doe	
51. NAME OF WITNESS John Doe		52. NAME OF PHYSICIAN Dr. J. H. Smith		53. NAME OF CORONER John Doe		54. NAME OF REGISTRAR Jane Doe		55. NAME OF WITNESS John Doe	
56. NAME OF PHYSICIAN Dr. J. H. Smith		57. NAME OF CORONER John Doe		58. NAME OF REGISTRAR Jane Doe		59. NAME OF WITNESS John Doe		60. NAME OF PHYSICIAN Dr. J. H. Smith	
61. NAME OF CORONER John Doe		62. NAME OF REGISTRAR Jane Doe		63. NAME OF WITNESS John Doe		64. NAME OF PHYSICIAN Dr. J. H. Smith		65. NAME OF CORONER John Doe	
66. NAME OF REGISTRAR Jane Doe		67. NAME OF WITNESS John Doe		68. NAME OF PHYSICIAN Dr. J. H. Smith		69. NAME OF CORONER John Doe		70. NAME OF REGISTRAR Jane Doe	
71. NAME OF WITNESS John Doe		72. NAME OF PHYSICIAN Dr. J. H. Smith		73. NAME OF CORONER John Doe		74. NAME OF REGISTRAR Jane Doe		75. NAME OF WITNESS John Doe	
76. NAME OF PHYSICIAN Dr. J. H. Smith		77. NAME OF CORONER John Doe		78. NAME OF REGISTRAR Jane Doe		79. NAME OF WITNESS John Doe		80. NAME OF PHYSICIAN Dr. J. H. Smith	
81. NAME OF CORONER John Doe		82. NAME OF REGISTRAR Jane Doe		83. NAME OF WITNESS John Doe		84. NAME OF PHYSICIAN Dr. J. H. Smith		85. NAME OF CORONER John Doe	
86. NAME OF REGISTRAR Jane Doe		87. NAME OF WITNESS John Doe		88. NAME OF PHYSICIAN Dr. J. H. Smith		89. NAME OF CORONER John Doe		90. NAME OF REGISTRAR Jane Doe	
91. NAME OF WITNESS John Doe		92. NAME OF PHYSICIAN Dr. J. H. Smith		93. NAME OF CORONER John Doe		94. NAME OF REGISTRAR Jane Doe		95. NAME OF WITNESS John Doe	
96. NAME OF PHYSICIAN Dr. J. H. Smith		97. NAME OF CORONER John Doe		98. NAME OF REGISTRAR Jane Doe		99. NAME OF WITNESS John Doe		100. NAME OF PHYSICIAN Dr. J. H. Smith	

RECEIVED  
BALTIMORE  
MAY 1955



12396

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	c. LENGTH OF STAY IN 1b <b>5 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b> <b>55</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sr. Mary Esther Catherine Underhill</b>		4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher Religious</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Underhill</b>		14. MOTHER'S MAIDEN NAME <b>Mary Burke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sr. Mary Ernest</b>		Address <b>6401 N. Charles Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ASCVD</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>2/20</b> , 19 <b>52</b> to <b>11/6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/20</b> , 19 <b>60</b> , and that death occurred at <b>12:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Vincent de Paul Fitzpatrick</i> M.D.		ADDRESS (Street, city or town, state) <b>1120 St Paul St</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Vincent de Paul Fitzpatrick</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-9-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Villa Maria Notch Cliff</b>
22d. LOCATION (City, town, or county) <b>Glenarm</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY W. JENKINS &amp; SONS</b>		ADDRESS <b>4405 YORK RD. BALT 12, MD</b>	24a. REC'D BY REGISTRAR <b>NOV 14 '60</b>
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—Baltimore 15

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12397

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12374

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>14</u> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3. V 01 - 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>420 West Franklin St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Dell</u> Last <u>Vance</u>				4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1897</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hospital attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William F. Vance</u>				14. MOTHER'S MAIDEN NAME <u>Carlie Shipman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Parkinson's Syndrome</u> DUE TO (c) <u>Cataracts - bilateral - Frac. femur; right; intertrochanteric</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Well leg traction applied to rt. hip on 11-23-60</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. fell to floor on 11-9-60 while on the way to dining room for breakfast, sustaining intertrochanteric frac. of rt. femur.</u>					
20c. TIME OF INJURY Month, Day, Year <u>11-9-1960</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>		20f. (City or town) (County) (State) <u>Catonville 28, Maryland</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. E. McGrath</u> EXAMINER'S NAME (Type) <u>W. E. McGrath, M. D.</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>11-25-60</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>3300 Old Frederick</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Foley</u>				ADDRESS <u>1318 Light</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlie Shipman</u>							

TO DEDUCE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12398

Items 6 & 9, Film G-278 1/8/61.cac.

CERTIFICATE OF DEATH

12375

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yrlmth5dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine, Maryland</b>		d. STREET ADDRESS <b>Springfield Road / 604-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>E.</b> Last <b>VanCleaf</b>		4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1887</b> <b>June 17, 1892</b>
9. AGE (In years lost birthday) <b>69</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>7</b> Hours <b>18</b> Min. <b>9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employed carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Charles VanCleaf</b>		14. MOTHER'S MAIDEN NAME <b>Sarah ---</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>215-07-3716</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 7, 1960</b> to <b>Nov. 4, 1960</b> , that (I) (we) lost saw the deceased alive on <b>Nov. 4, 1960</b> , and that death occurred at <b>2:55 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachsler</b>		22b. DATE SIGNED <b>11-4-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cath. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Clinton Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home</b>		25a. REC'D BY REGISTRAR <b>NOV 15 '60</b>	
ADDRESS <b>Upper Marlboro, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



13302

CHIEF TALK

CONCULCA

CHIEF TALK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12399

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12376

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 174 Rt. 16 Bird River Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>E.</u> Last <u>Vaughan</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1881</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Enoch Llewellyn</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>319-28-3561</u>		17. INFORMANT <u>David E. Jones 2921 Northwind Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis, Severe</u> DUE TO <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 19 58</u> to <u>Nov 15 19 60</u> , that (I) (we) last saw the deceased alive on <u>Nov 1 19 60</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Theodore E. Evans</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov 15, 1960</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>11-17-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset</u>		23d. LOCATION (City, town, or county) (State) <u>Granite City, Illinois.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		25a. REC'D BY REGISTRAR <u>NOV 16 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>C. L. Evans</u>			

12333

CERTIFICATE OF DEATH

12333



Blank certificate form with faint horizontal lines and vertical columns for data entry.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12377

12400

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Randallstown, Ind.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Randallstown, Ind.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Liberty Rd.</u>		d. STREET ADDRESS <u>1 Liberty Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>MYRTLE ELIZ. VON GUNTEN</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-29-1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Balto., Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Elliott.</u>		14. MOTHER'S MAIDEN NAME <u>Lena Knauss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-249810</u>	
17. INFORMANT <u>Christian R. Von Gunten</u>		Address <u>Same.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic C-V. Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>asthma</u>			
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>No.</u>		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <u>none</u>	
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. <u>noon</u> p.m. <u>9</u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>none</u>	
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		2Df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. CAPLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-16-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Paran</u>		22d. LOCATION (City, town, or country) (State) <u>Harrisonville, Maryland</u>	
23. FUNERAL DIRECTOR <u>Loring Byers, 8728 Liberty Rd., Randallstown, Ind.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '60</u>	
ADDRESS <u>8728 Liberty Rd., Randallstown, Ind.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knauss</u>	

DATE SIGNED  
11-14-'60

13400

13400

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Handwritten signature and text at the bottom of the page.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12378

12401

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>				c. LENGTH OF STAY IN 1b <b>54 ESSEX</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>315 TOWNSEND RD</b>				d. STREET ADDRESS <b>1315 TOWNSEND RD.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>CHARLES JAMES VRANY</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>1960</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 14-1891</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CABINET MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NATL. STORE FIX.</b>		11. BIRTHPLACE (State or foreign country) <b>CHECHOSLOVAKIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>VACLAV VRONY</b>			14. MOTHER'S MAIDEN NAME <b>MARIE BENAIK</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-01-6884</b>		17. INFORMANT Address <b>JOSEPHINE VRANY (SAME AS ABOVE)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cardiac failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerotic cardio-</b> DUE TO <b>vascular disease</b> (c) <b>1 yr</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 4 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 2, 1959</b> to <b>Nov. 22, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 22, 1960</b> , and that death occurred on <b>Nov. 22, 1960</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph Miceli M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH MICELI M.D.</b>				22d. ADDRESS <b>108 N. Taylor Ave Balto 21, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>NOV. 25-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BOHEMIA NATL. CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connolly</b>				ADDRESS <b>418 Eastern Blvd Balto 21 Md</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 28 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur J. Thomas</b>			

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12401

CERTIFICATE OF MAIL

U.S. POSTAL SERVICE  
DIVISION OF INVESTIGATION  
WASHINGTON, D.C.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12402 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12379

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any, or as necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal of the body in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River (20)</u>		c. LENGTH OF STAY IN 1b <u>54</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River (20)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13 Sunflower Lane, Trailer Village</u>			d. STREET ADDRESS <u>13 Sunflower Lane, Trailer Village</u>		
3. NAME OF DECEASED (Type or print) <u>Chauncey Koch Waitt</u>			4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1904</u>		9. AGE (In years last birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Everett F. Waitt</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>270-01-6461</u>		17. INFORMANT <u>Gladys Waitt</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shoot - in - Rt. Parietal area</u> <u>976 X</u> DUE TO (b) <u>38 Cal Pistol</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self in Rt. Skull</u>			
20c. TIME OF INJURY Month, Day, Year <u>11-23 1960</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. City or town <u>Middle River - Baltimore</u>		20g. (County) <u>Baltimore</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/23/60.</u>	
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Balto., Md.</u>		22e. (State) <u>Md.</u>		22f. REC'D BY REGISTRAR <u>NOV 28 '60</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bruzdinski</u>		ADDRESS <u>1407 Eastern Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kraus</u>	

FOR STATE  
HEALTH DEPT



RECEIVED  
JAN 10 1915  
STATE DEPT OF HEALTH  
Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
13405 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>	RACE <i>White</i>
RESIDENCE <i>123 Main St, Baltimore, Md.</i>		OCCUPATION <i>Teacher</i>		
DATE OF DEATH <i>Jan 5, 1915</i>		PLACE OF DEATH <i>Home</i>		
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		
SIGNATURE OF EXAMINER <i>Dr. J. H. Smith</i>		DATE <i>Jan 10, 1915</i>		
LOCAL HEALTH OFFICER <i>Wm. H. Jones</i>		COUNTY CLERK <i>John A. Brown</i>		
MAYOR <i>John B. Smith</i>		COMMISSIONER OF HEALTH <i>Dr. J. H. Smith</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
12403  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12380

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>10 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>H.</u> Last <u>WALKER</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/23</u>
9. AGE (In years lost birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Walker</u>		14. MOTHER'S MAIDEN NAME <u>Etta Bailey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>215-16-5972</u>	
17. INFORMANT <u>Clin. Rec. VAH, Balto. Md. Fort Howard Division</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>491X</u> <u>DEMA</u> (b) <u>EDEMA OF LUNGS</u> <u>XXDEMA</u> (c) <u>HYPERTROPHY AND DILATION OF THE HEART</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>3 DAYS</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>my</u> (this hospital) attended the deceased from <u>Nov. 16</u> 19 <u>60</u> , to <u>Nov. 26</u> 19 <u>60</u> , that <u>my</u> (we) last saw the deceased alive on <u>Nov. 26</u> 19 <u>60</u> , and that death occurred at <u>1:10AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George C. McElPatrick</u>		22b. DATE SIGNED <u>11/26/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE C. McELPATRICK, M.D.</u>		22d. ADDRESS <u>VAH, Balto. Md. Fort Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/30/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 1 '60</u>	
ADDRESS <u>1808 N. Monroe Street</u> <u>Baltimore, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

15203

WILLIAM J. BROWN

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12381

12404

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>				c. LENGTH OF STAY IN 1b <b>24 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>College Manor Nursing Home</b>				d. STREET ADDRESS <b>Cambridge Arms Apts.</b>			
3. NAME OF DECEASED (Type or print) <b>George Frank Ward</b>				4. DATE OF DEATH <b>November 16, 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 9, 1874</b>	
9. AGE (In years lost birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Accomac, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>George Frank Ward</b>				14. MOTHER'S MAIDEN NAME <b>Betty Drummond Bloxon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Nathaniel M. Ward Greensboro, North Carolina</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basal Cell Carcinoma of 5th toe</b> DUE TO (b) <b>metastases</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (c), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/6/46</b> , 19____, to <b>11/16/60</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/15/60</b> , 19____, and that death occurred at <b>11:35 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Francis W. Gluck</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/17/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Francis W. Gluck</b>				22d. ADDRESS <b>100 West University Parkway</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>November 18, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc.</b>				ADDRESS <b>1900 Eutaw Place</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 18 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

15204

1



12405

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROGERS FORGE</b>		c. LENGTH OF STAY IN 1b <b>9 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROGERS FORGE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>118 GLEN ARGYLE RD.</b>				d. STREET ADDRESS <b>118 GLEN ARGYLE RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First <b>ROBERT</b>		Middle <b>WARD, SR.</b>		Last	
4. DATE OF DEATH <b>11</b>		Month <b>25</b>		Day <b>1960</b>		Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 22, 1883</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STREET CAR OPERATOR-BALTO. TRANSIT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>		11. BIRTHPLACE (State or foreign country) <b>USA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>ROBERT WARD</b>				14. MOTHER'S MAIDEN NAME <b>DOLLIE ROMOSER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-10-2680</b>		INFORMANT Address <b>RUTH HARBSTREET 1814 VISTA LANE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>502.1</b> DUE TO <b>Acute Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> (c) <b>ACUTE PULMONARY HEMORRHAGE</b> <b>CHRONIC BRONCHITIS.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b> <b>1 day</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> , to <b>now</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Sept</b> , 19 <b>60</b> , and that death occurred at <b>2:15</b> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George H. Beech</b>		ADDRESS (Street, city or town, state) <b>6012 Harford Road BALTO, MD 11/26/60</b>					
PHYSICIAN'S NAME (Type) <b>GEORGE H. BEECH MD.</b>		DATE <b>6012 HARFORD ROAD BALTO, MD 11/26/60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/29/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>		22d. LOCATION (City, town, or county) _____ (State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B.W. Hoffmann</b>				ADDRESS <b>3218 HUDSON ST. (24)</b>		24a. REC'D BY REGISTRAR <b>NOV 28 60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18105

ROBERT

M.D.

ROBERT FORGE

P. 100

ROBERT FORGE

IN CLINICAL

IN CLINICAL

WILLIAM

ROBERT

ROBERT

M.D. WHITE

18105

18105

ROBERT FORGE

M.D.

ROBERT WARD

18105

NO. 18105



M.D.

ROBERT

ROBERT

ROBERT WARD

12406

CERTIFICATE OF DEATH

Reg. Dist. No.

12383

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr 13dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lester</b> Middle <b>Waterman</b> Last <b>Waterman</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1882</b>
9. AGE (In years lost birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Moses J. Waterman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Brager</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420-1</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1960</b> to <b>Nov. 21, 1960</b> and that death occurred at <b>11:10 AM</b> , from the causes and on the date stated above. a. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>11-21-60</b>			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/22/60;</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oheb Shalom Cong.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Ma.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Levinson &amp; Bros. Inc. 6010 Reist. Rd.</b>		24. REGISTRAR'S SIGNATURE <b>NOV 23 60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1946

1946

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12407

## CERTIFICATE OF DEATH

## 12384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mary land</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>5 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>34 Oaklee Village</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Russell</b> Last <b>Weber</b>				4. DATE OF DEATH Month <b>November</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 14, 1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>pipe fitter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Unknown OTTO Weber</b>				14. MOTHER'S MAIDEN NAME <b>Unknown SARAH E. Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>1E3-83-6181</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pyelonephritis and azotemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemorrhagic urinary cystitis</b> DUE TO (c) <b>Carcinoma of Prostate</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Dis with Infarctive cardiac fibrosis and cardiac aneurysm</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov. 1, 1960</b> , to <b>Nov. 23, 1960</b> , that I last saw the deceased alive on <b>Nov. 23, 1960</b> , and that death occurred at <b>5:55 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>José R. Arizaga</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>			
PHYSICIAN'S NAME (Type) <b>JOSE R. ARIZAGA, M.D.</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Coleman</b>				ADDRESS <b>6067 Hays Rd</b>			
24a. REC'D BY REGISTRAR <b>12/28/60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12385

12408

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b> c. LENGTH OF STAY IN lb <b>50 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5033 Pembridge Avenue (15)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>-----</b> Last <b>WEINBERG</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 15, 1895</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b>		IF UNDER 24 HRS. Hours <b>65</b> Min. <b>65</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tailoring</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Abraham Weinberg</b>				14. MOTHER'S MAIDEN NAME <b>Zilda MN: Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 216-01-3467</b>		17. INFORMANT <b>Clinical Records VAH, Baltimore 18, Md. FORT HOWARD DIVISION</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERIVESICAL ABSCESS WITH EXTENSION INTO THE WALL OF ABDOMEN, RIGHT SIDE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>HYPERTROPHY AND DILATATION OF THE HEART</b> (b) <b>EDEMA OF THE LUNGS, MODERATE</b> (c) <b>OLD CEREBRAL INFARCT RIGHT HEMISPHERE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>OLD CEREBRAL INFARCT RIGHT HEMISPHERE</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>6 WEEKS UNKNOWN</b> <b>2 DAYS</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>September 22, 1960</b> to <b>November 18, 1960</b> , that <del>he</del> (we) last saw the deceased alive on <b>Nov. 18, 1960</b> , and that death occurred at <b>7:19</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Frederick S. Donaldson</b>				22b. DATE SIGNED <b>11/18/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>				22d. ADDRESS <b>VAH, BALTIMORE 18 MD., FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-20-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis, Inc. 2100 Eutaw Place, Balto. Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 21 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS  
COUNTY OF DALLAS

1910

Know all men by these presents, that

JOHN A. DAVIS, of the County of Dallas, State of Texas,

do hereby certify that the within and foregoing is a true and correct copy of the

original thereof, as the same appears from the records of the County of Dallas, State of Texas,

in and to which said original has been duly filed for record, in accordance with the provisions of the

Act of the Legislature of the State of Texas, approved March 21, 1909, Chapter 100, Section 1.

Witness my hand and the seal of the County of Dallas, this 1st day of January, 1910.

JOHN A. DAVIS, County Clerk of Dallas County, Texas.

My commission expires the 1st day of January, 1911.

JOHN A. DAVIS, County Clerk of Dallas County, Texas.

My commission expires the 1st day of January, 1911.

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My commission expires the 1st day of January, 1911.

JOHN A. DAVIS, County Clerk of Dallas County, Texas.

My commission expires the 1st day of January, 1911.



# CERTIFICATE OF DEATH

1899

(1)

NAME

AGE

SEX

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PLACE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12410

12387

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>12 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		(6)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>8100 Philadelphia Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CLAUDE</b>		Middle <b>E.</b>		Last <b>WHITE</b>		4. DATE OF DEATH Month <b>November</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 1, 1897</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman</b>		11. BIRTHPLACE (State or foreign country) <b>Rushville, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Benjamin E. White</b>		14. MOTHER'S MAIDEN NAME <b>Queen Loudon</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>094-03-2396</b>	
17. INFORMANT <b>Clinical Records</b>		Address <b>VAH, Baltimore 18, Maryland, FORT HOWARD DIVISION</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FIBROCASEOUS TUBERCULOSIS OF THE LUNGS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>EDEMA OF THE LUNGS</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>2 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>November 17, 1960</b> <b>November 29, 1960</b>	
21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>November 17, 1960</b> to <b>November 29, 1960</b> , that <b>XX</b> (we) last saw the deceased alive on <b>Nov. 29, 1960</b> , and that death occurred at <b>7:08 A. M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Fredrick S. Donaldson</b>		22b. DATE SIGNED <b>11/29/60</b>		22c. PHYSICIAN'S NAME (Type) <b>FREDERICK S. DONALDSON, M.D.</b>	
22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-1-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
23d. LOCATION (City, town, or county) (State) <b>Baltimore</b> <b>Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14</b>		25a. REC'D BY REGISTRAR <b>NOV 30 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinner</b>	

Md.



15410

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH  
OFFICE OF VITAL RECORDS - BUREAU OF VITAL RECORDS

( )

J. H. A.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12411

12388

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b <b>5 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>				d. STREET ADDRESS <b>3012 Putty Hill Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Mary</b> Last <b>Wienhold</b>				4. DATE OF DEATH Month <b>11</b> Day <b>14</b> Year <b>1960</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/28/1876</b>		
9. AGE (In years lost birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b>		IF UNDER 24 HRS. Hours <b>11</b> Min. <b>00</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Hochel Bavaria</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>								
13. FATHER'S NAME <b>Albert Engelman</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth McBow</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Admission Record</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>ASCVD.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>September 1960</b> to <b>November 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 14th 1960</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.								
22a. SIGNATURE <b>Robert Mahon M.D.</b>				22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <b>Robert Mahon -M.D.</b>				22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-17-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		23d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>CHAS. F. EVANS + SON</b>				25a. REC'D BY REGISTRAR <b>8802 HARFORD RD</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
12412 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12389														
1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>									
c. LENGTH OF STAY IN 1b <b>30 yrs.</b>					d. STREET ADDRESS <b>York Road Cockeysville</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>York Road</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Joseph Marvey Wilhelm</b>					4. DATE OF DEATH Month <b>11</b> Day <b>14</b> Year <b>60</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-14-1891</b>		9. AGE (In years last birthday) <b>69</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tool Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> Hours <b>19</b> Min. <b>60</b>						
13. FATHER'S NAME <b>David F. Wilhelm</b>					14. MOTHER'S MAIDEN NAME <b>Ida H. Hampshire</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>W.W. I</b>					16. SOCIAL SECURITY NO. <b>216-07-4595</b>					17. INFORMANT <b>Harry Wilhelm Wilmar Place, Cockeysville</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Sudden</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Charles F. O'Donnell</b> <b>11/14/60</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>11-16-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Baptist</b>		22d. LOCATION (City, town, or country) (State) <b>Parkton, Maryland</b>					
23. FUNERAL DIRECTOR <b>Brooks Funeral Service</b>					ADDRESS <b>Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 16 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Charles F. O'Donnell</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Items 8,9 Film G276 12-5-60 et									
12413									
CERTIFICATE OF DEATH									
Reg. Dist. No. 12391									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>					c. LENGTH OF STAY IN 1b <b>Catonsville</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1 Briarwood Rd</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>H</b> Last <b>Williamson</b>					4. DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>1960</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 29, 1908</b>		9. AGE (In years last birthday) <b>52</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Concrete</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Isaac C. Williamson</b>					14. MOTHER'S MAIDEN NAME <b>Margaret D.</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WW2</b>					16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. James H. Williamson Catons, Md</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420-1</b> DUE TO <b>Coronary thromboses</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic CVD</b> (c) <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>10</b> , 19 <b>56</b> , to <b>11/22</b> , 19 <b>60</b> that I last saw the deceased alive on <b>10/20</b> , 19 <b>60</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>James Nolan</b>					ADDRESS (Street, city or town, state) <b>416 Kensington Rd Baltimore Md</b>				
PHYSICIAN'S NAME (Type) <b>J J NO LAN</b>					DATE SIGNED <b>11/23/60</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 24, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley- Cavanaugh F. H. Catonsville Md.</b>					24a. REC'D BY REGISTRAR DATE <b>NOV 29 '60</b>				
					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>				

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-PARKTON</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL-PARKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>G-RACE</u> Middle <u>ANNIE</u> Last <u>WILSON</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 22, 1894</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	IF UNDER 24 HRS. Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Cornelius Wilson</u>	
14. MOTHER'S MAIDEN NAME <u>Evelyn Emma Young</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Miss Nellie Wilson, Parkton RD 2 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/16/60</u> , 19 <u>60</u> , to <u>11/19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11/19/60</u> , 19 <u>60</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. M. France</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>PARKTON, MD</u> <u>11/19/60</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/22/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Rayville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kutz</u>		ADDRESS <u>Jarrettsville Md.</u>	24a. REC'D BY REGISTRAR <u>NOV 22 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1941

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

VS. A15ME  
5M 7/59

12213  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12394

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halsethorpe</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5724 1st. Ave</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halsethorpe</u> d. STREET ADDRESS <u>5724 1st. Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie Hamilton Wilson</u>				4. DATE OF DEATH Month Day Year <u>Nov. 23, 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21, 1876</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home duties</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James R. Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Annie D. Keys</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Elmo Gens, 5724 1st Ave, Halsethorpe</u> <u>Edith Gens, 5619 Ashbourne Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation. Strangulation</u> DUE TO <u>Choking while eating food . Accident</u> Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Choked on food while eating her meal</u>					
20c. TIME OF INJURY Month, Day, Year <u>Hour 11-11-60</u> <u>8 - p.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Halsethorpe Balto. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1010 Leeds Ave</u>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Balto. Co. Md. 11/23, 1960</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard 4107 Wilkens Ave.</u>				24a. REC'D BY REGISTRAR <u>NOV 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

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15313 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15313  
15313

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Howard H. Hubbard, 11/20/60, Green Lawn Cemetery, Maryland  
11/20/60

## CERTIFICATE OF DEATH

12395

Reg. Dist. No.

12416

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cotonsville</u>		c. LENGTH OF STAY IN 1b <u>1-yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>410 Wrenleigh Drive</u>		d. STREET ADDRESS <u>410 Wrenleigh Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Wise</u> Middle Last		4. DATE OF DEATH <u>Nov 14</u> Month Day Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1869</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Molder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles J. Wise</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Alice T. Wise - 410 Wrenleigh Dr.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bleeding Duodenal Ulcer</u> <u>450.00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>No Union of fracture right tibia - July 19, 1952</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 13, 1960</u> to <u>Nov 14, 1960</u> , that I last saw the deceased alive on <u>Nov 13, 1960</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl Pass</u> M.D.		ADDRESS (Street, city or town, state) <u>4001 Wilkens Airport Rd - 94411-16-60</u>	
PHYSICIAN'S NAME (Type) <u>I. EARL PASS, M.D.</u>		DATE SIGNED <u>Nov 14-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/17/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Towson Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. H. Wippert - 1700 E. Towson Rd.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	
DATE <u>NOV 18 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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12417  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12396

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr3mth10dys		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 3433 Old Frederick Road		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William Robert Wise		4. DATE OF DEATH Month November 6, 1960		Day 6		Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 21, 1908	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver		10b. KIND OF BUSINESS OR INDUSTRY bakery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles S. Wise		14. MOTHER'S MAIDEN NAME Louise Goodwin							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary metastases with necrosis DUE TO 141-9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous cell carcinoma of tongue DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 mo 1 1/2 years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 28, 1960, to Nov. 6, 1960, that (I) (we) last saw the deceased alive on Nov. 6, 1960, and that death occurred 10 A. M. from the causes and on the date stated above.									
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) STELLA WACHSLER		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 8, 1960		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		23d. LOCATION (City, town, or county) Balto. Md		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE G. Truman Schwab		ADDRESS 3512 Frederick Ave. (29)		25a. REC'D BY REGISTRAR DATE NOV 9 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

1941

CERTIFICATE OF DEATH

1941

Blank certificate form with faint lines and text, including a large circular stamp on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12418

CERTIFICATE OF DEATH

12397

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto. Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>52</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6607 Kannah St. County</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		d. STREET ADDRESS <u>Catonsville 28 Md.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES WISKOW</u>		4. DATE OF DEATH <u>Nov. 25</u> 19 <u>60</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19, 1865</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Herman Wiskow</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MM Louise Heinmuller</u>	
17. INFORMANT <u>MM Louise Heinmuller</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia Terminal</u> 442x DUE TO (b) <u>Cardio Vascular Renal Disease Serial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> to <u>11/25</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11/25</u> 19 <u>60</u> and that death occurred at <u>PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Elot W. Johnson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Elot W. Johnson</u>		22d. ADDRESS <u>3432 Madison Ave Baltimore 29 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/28/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mudraff &amp; Son</u>		ADDRESS <u>28</u>	
25a. REC'D BY REGISTRAR <u>NOV 29 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



**1**  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12392  
**12414 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN lb <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sheppard &amp; Pratt</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rising Sun - Rural</u> d. STREET ADDRESS <u>07X2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Bennett</u> Last <u>Wilson</u>			4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-1897</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Cecil Co, Md.</u>			
13. FATHER'S NAME <u>Samuel D. Wilson</u>			14. MOTHER'S MAIDEN NAME <u>Mary Mendenhall</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>312-30-7832</u>		17. INFORMANT Address <u>Mrs. Bennett Wilson Rising Sun Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9774X</u> DUE TO <u>Asphyxiation from Strangulation</u> Conditions, if any, which gave rise to immediate cause (b) <u>From Hanging</u> (c) <u>Sudden</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/14/60</u>			
EXAMINER'S NAME (Type) <u>Charles F O'Donnell</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-17-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Rising Sun Md.</u>				
23. FUNERAL DIRECTOR <u>Yoman E. M. Miller</u> ADDRESS <u>Rising Sun Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 16 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12419

**CERTIFICATE OF DEATH**

12398

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. LENGTH OF STAY IN 1b <u>14 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sherry</u> Middle <u>Lynn</u> Last <u>Woodall</u>				4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-30-60</u>	
9. AGE (In years lost birthday) <u>-</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland - BALTO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Jack E Woodall</u> <u>150 Frederick Rd; Ellicott City Md.</u>				14. MOTHER'S MAIDEN NAME <u>BETTY GOLDSMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Institution records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalocyst; meningitis -</u> <u>751X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myelocyst,</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from <u>11-10-1960</u> to <u>11-24-1960</u> , that (s) (we) last saw the deceased alive on <u>11-24-1960</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Peter U. Rieckert, Pathologist</u>				22b. DATE <u>11-24-60</u>		22c. ADDRESS <u>4307 Mainfield Ave, Balto 14 Md</u>	
22c. PHYSICIAN'S NAME (Type) <u>Peter U. Rieckert</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-24-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GOOD SHEPHERD</u>		23d. LOCATION (City, town, or county) (State) <u>ELlicott City Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F.S. HIGGINS</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Encephalitis; meningitis -  
infectious

Water & Rice West  
to Hospital. Hospital

X

4302 Main - field and hospital

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

12399

12420

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. LENGTH OF STAY IN 1b <b>X BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2002 KERNAN DR</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>2 BENJAMIN Middle (NMI) ZITTRAIN Last</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1891</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chef</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Schrieber Brothers</b>	
11. BIRTHPLACE (State or foreign country) <b>Boston, Mass.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>----- Zittrain</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT <b>Mr. Lawrence Zittrain-2002 Kernan Drive #7</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH.</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/18, 1960</b> to <b>11/27, 1960</b> , that I last saw the deceased alive on <b>11/27, 1960</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1127/60 DATE SIGNED</b>			
ACTUAL SIGNATURE <b>Herbert L. Blumenfeld</b> M.D.		2104 Gwynn Oak Av	
PHYSICIAN'S NAME (Type) <b>HERBERT L. BLUMENFELD</b>		<b>BALTIMORE 7, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/29/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tichewsky</b>		24a. REC'D BY REGISTRAR <b>NOV 28 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF DEATH

1943

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>	
<p>2. Date of death: <u>10/15/43</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Cause of death: <u>Heart Disease</u></p>	
<p>5. Manner of death: <u>Natural</u></p>	
<p>6. Age at death: <u>65</u></p>	
<p>7. Sex: <u>Male</u></p>	
<p>8. Race: <u>White</u></p>	
<p>9. Marital status: <u>Married</u></p>	
<p>10. Occupation: <u>Engineer</u></p>	
<p>11. Education: <u>High School</u></p>	
<p>12. Date of birth: <u>10/15/78</u></p>	
<p>13. Place of birth: <u>New York City</u></p>	
<p>14. Date of arrival in country: <u>1900</u></p>	
<p>15. Date of departure from country: <u>1943</u></p>	
<p>16. Date of return to country: <u>1943</u></p>	
<p>17. Date of death: <u>10/15/43</u></p>	
<p>18. Date of burial: <u>10/18/43</u></p>	
<p>19. Date of cremation: <u>None</u></p>	
<p>20. Date of interment: <u>10/18/43</u></p>	
<p>21. Date of removal: <u>None</u></p>	
<p>22. Date of return: <u>None</u></p>	
<p>23. Date of death: <u>10/15/43</u></p>	
<p>24. Date of burial: <u>10/18/43</u></p>	
<p>25. Date of cremation: <u>None</u></p>	
<p>26. Date of interment: <u>10/18/43</u></p>	
<p>27. Date of removal: <u>None</u></p>	
<p>28. Date of return: <u>None</u></p>	
<p>29. Date of death: <u>10/15/43</u></p>	
<p>30. Date of burial: <u>10/18/43</u></p>	
<p>31. Date of cremation: <u>None</u></p>	
<p>32. Date of interment: <u>10/18/43</u></p>	
<p>33. Date of removal: <u>None</u></p>	
<p>34. Date of return: <u>None</u></p>	
<p>35. Date of death: <u>10/15/43</u></p>	
<p>36. Date of burial: <u>10/18/43</u></p>	
<p>37. Date of cremation: <u>None</u></p>	
<p>38. Date of interment: <u>10/18/43</u></p>	
<p>39. Date of removal: <u>None</u></p>	
<p>40. Date of return: <u>None</u></p>	
<p>41. Date of death: <u>10/15/43</u></p>	
<p>42. Date of burial: <u>10/18/43</u></p>	
<p>43. Date of cremation: <u>None</u></p>	
<p>44. Date of interment: <u>10/18/43</u></p>	
<p>45. Date of removal: <u>None</u></p>	
<p>46. Date of return: <u>None</u></p>	
<p>47. Date of death: <u>10/15/43</u></p>	
<p>48. Date of burial: <u>10/18/43</u></p>	
<p>49. Date of cremation: <u>None</u></p>	
<p>50. Date of interment: <u>10/18/43</u></p>	
<p>51. Date of removal: <u>None</u></p>	
<p>52. Date of return: <u>None</u></p>	
<p>53. Date of death: <u>10/15/43</u></p>	
<p>54. Date of burial: <u>10/18/43</u></p>	
<p>55. Date of cremation: <u>None</u></p>	
<p>56. Date of interment: <u>10/18/43</u></p>	
<p>57. Date of removal: <u>None</u></p>	
<p>58. Date of return: <u>None</u></p>	
<p>59. Date of death: <u>10/15/43</u></p>	
<p>60. Date of burial: <u>10/18/43</u></p>	
<p>61. Date of cremation: <u>None</u></p>	
<p>62. Date of interment: <u>10/18/43</u></p>	
<p>63. Date of removal: <u>None</u></p>	
<p>64. Date of return: <u>None</u></p>	
<p>65. Date of death: <u>10/15/43</u></p>	
<p>66. Date of burial: <u>10/18/43</u></p>	
<p>67. Date of cremation: <u>None</u></p>	
<p>68. Date of interment: <u>10/18/43</u></p>	
<p>69. Date of removal: <u>None</u></p>	
<p>70. Date of return: <u>None</u></p>	
<p>71. Date of death: <u>10/15/43</u></p>	
<p>72. Date of burial: <u>10/18/43</u></p>	
<p>73. Date of cremation: <u>None</u></p>	
<p>74. Date of interment: <u>10/18/43</u></p>	
<p>75. Date of removal: <u>None</u></p>	
<p>76. Date of return: <u>None</u></p>	
<p>77. Date of death: <u>10/15/43</u></p>	
<p>78. Date of burial: <u>10/18/43</u></p>	
<p>79. Date of cremation: <u>None</u></p>	
<p>80. Date of interment: <u>10/18/43</u></p>	
<p>81. Date of removal: <u>None</u></p>	
<p>82. Date of return: <u>None</u></p>	
<p>83. Date of death: <u>10/15/43</u></p>	
<p>84. Date of burial: <u>10/18/43</u></p>	
<p>85. Date of cremation: <u>None</u></p>	
<p>86. Date of interment: <u>10/18/43</u></p>	
<p>87. Date of removal: <u>None</u></p>	
<p>88. Date of return: <u>None</u></p>	
<p>89. Date of death: <u>10/15/43</u></p>	
<p>90. Date of burial: <u>10/18/43</u></p>	
<p>91. Date of cremation: <u>None</u></p>	
<p>92. Date of interment: <u>10/18/43</u></p>	
<p>93. Date of removal: <u>None</u></p>	
<p>94. Date of return: <u>None</u></p>	
<p>95. Date of death: <u>10/15/43</u></p>	
<p>96. Date of burial: <u>10/18/43</u></p>	
<p>97. Date of cremation: <u>None</u></p>	
<p>98. Date of interment: <u>10/18/43</u></p>	
<p>99. Date of removal: <u>None</u></p>	
<p>100. Date of return: <u>None</u></p>	

DEPARTMENT OF HEALTH - BATHING, 18

1. Name of deceased: JOHN J. BROWN

2. Date of death: 10/15/43

3. Place of death: Home

4. Cause of death: Heart Disease

5. Manner of death: Natural

6. Age at death: 65

7. Sex: Male

8. Race: White

9. Marital status: Married

10. Occupation: Engineer

11. Education: High School

12. Date of birth: 10/15/78

13. Place of birth: New York City

14. Date of arrival in country: 1900

15. Date of departure from country: 1943

16. Date of return to country: 1943

17. Date of death: 10/15/43

18. Date of burial: 10/18/43

19. Date of cremation: None

20. Date of interment: 10/18/43

21. Date of removal: None

22. Date of return: None

23. Date of death: 10/15/43

24. Date of burial: 10/18/43

25. Date of cremation: None

26. Date of interment: 10/18/43

27. Date of removal: None

28. Date of return: None

29. Date of death: 10/15/43

30. Date of burial: 10/18/43

31. Date of cremation: None

32. Date of interment: 10/18/43

33. Date of removal: None

34. Date of return: None

35. Date of death: 10/15/43

36. Date of burial: 10/18/43

37. Date of cremation: None

38. Date of interment: 10/18/43

39. Date of removal: None

40. Date of return: None

41. Date of death: 10/15/43

42. Date of burial: 10/18/43

43. Date of cremation: None

44. Date of interment: 10/18/43

45. Date of removal: None

46. Date of return: None

47. Date of death: 10/15/43

48. Date of burial: 10/18/43

49. Date of cremation: None

50. Date of interment: 10/18/43

51. Date of removal: None

52. Date of return: None

53. Date of death: 10/15/43

54. Date of burial: 10/18/43

55. Date of cremation: None

56. Date of interment: 10/18/43

57. Date of removal: None

58. Date of return: None

59. Date of death: 10/15/43

60. Date of burial: 10/18/43

61. Date of cremation: None

62. Date of interment: 10/18/43

63. Date of removal: None

64. Date of return: None

65. Date of death: 10/15/43

66. Date of burial: 10/18/43

67. Date of cremation: None

68. Date of interment: 10/18/43

69. Date of removal: None

70. Date of return: None

71. Date of death: 10/15/43

72. Date of burial: 10/18/43

73. Date of cremation: None

74. Date of interment: 10/18/43

75. Date of removal: None

76. Date of return: None

77. Date of death: 10/15/43

78. Date of burial: 10/18/43

79. Date of cremation: None

80. Date of interment: 10/18/43

81. Date of removal: None

82. Date of return: None

83. Date of death: 10/15/43

84. Date of burial: 10/18/43

85. Date of cremation: None

86. Date of interment: 10/18/43

87. Date of removal: None

88. Date of return: None

89. Date of death: 10/15/43

90. Date of burial: 10/18/43

91. Date of cremation: None

92. Date of interment: 10/18/43

93. Date of removal: None

94. Date of return: None

95. Date of death: 10/15/43

96. Date of burial: 10/18/43

97. Date of cremation: None

98. Date of interment: 10/18/43

99. Date of removal: None

100. Date of return: None